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Guy's Hospital, London

PASSIM

Cancer

Eras are distinguished by their greatest men, their imperial nations, their wars and their discoveries, and by their diseases. The Black Death and Tuberculosis have played their dark rôles in history, but in the public eye the infections have yielded their chair of death to the "new killer", *cancer*. Perhaps the incidence of malignant neoplasms has risen by a degree which may constitute a "new" problem, but some of this is explicable on the basis of a population which is more able to survive disease of other sorts. Even if the incidence is increasing, the most remarkable and concerning aspect is the public attitude to this vast class of conditions. With very few exceptions, it is an attitude of unreasoning, unknowing, but pardonable fear.

This fear is all for the good, some may object, for it brings many a patient to the doctor when cancer is suspected. Yet even this is questionable. A blind fear of cancer may drive the over-anxious patient to seek advice on the slightest provocation, to be reassured and discharged again and again, by a doctor very slightly exasperated and each time a little less careful. The end-result is a patient classed "neurotic" by the doctor, and that temptation to dismiss the patient's latest complaint as yet another symptom of anxiety, with the occasional disastrous result.

Another patient with genuine cancer may react in a more dangerous fashion, may yield to that strange human whim of escapism, and suppress his terrible thoughts of that "gnawing, eating, eroding growth" within him. He dreads the finality of that professional opinion. It is the very fear of knowing that sentence of *cancer* which keeps him away, until pain or family force him to seek attention, too desperate for comfort and too late for cure.

At least from one source, the education of the public in the nature and treatment of cancer is beginning and we would hope that this continue and expand. Nothing but happier lives and fewer deaths can come from a greater knowledge of the conditions included in that death-shrouded rattle of a word. Knowledge of the early signs and symptoms will lead to earlier diagnosis. Knowledge of treatment will lead to confidence and hope where there is now only the despair of ignorance. Until we can squarely tell our patient, "You have cancer", then he, the public, knows too little about it. And the fault is surely ours.

Knowledge of cancer and its management is not only to be recommended to the public, but to their doctors also. We are pleased to announce a new item to appear regularly in the Guy's calendar, the "Radiotherapy Tumour Conference". The object of these meetings is to bring together all those interested in the diagnosis and treatment of cancer, and to correlate the various methods of treat-

ment, their uses and limitations. Various speakers will give their specialised contributions, followed by a general discussion. These conferences should provide a much-needed source of cohesive thought on this subject of controlling cancer, in which so many forms of treatment are utilised. The first meeting will take place on the 20th January, and thereafter meetings will occur on the third Wednesday of each month, at 2.15 p.m. Students will be particularly welcome.

Elsewhere Unlucky

Now that the housemen are settled into their new and luxurious rooms it would be pertinent to recall the days in the College and congratulate past and present inhabitants on the fortitude with which they tolerated their abysmal lot.

Throughout the country, housemen are having to contend with conditions which few other people would put up with, and after working long hours they return to rooms—home for many—which are both depressing and uncomfortable. The fault lies with successive governments who have shut their eyes to the plight of the newly-qualified doctor. The profession imposes a compulsory year's service in hospital and the State neither feeds, pays nor houses these time-servers in a manner which they merit. Many hospital authorities suffer a paucity of carpets and ideas with which to furnish and decorate rooms. A succession of inhabitants have little time or energy to complain of their lot.

Very few hospitals have married accommodation and those that have can claim many applicants for a vacancy. There is no shortage of staff in those hospitals which manage to provide the facilities that are the young doctor's right. Many of those who enter the Forces do so because of the amenities that they will enjoy in this aspect of medicine. To be both dissatisfied and discontented does not bring out the best in anyone, nor does it make a better doctor.

GUY'S DIARY

JANUARY.

EXHIBITION.			*Post-operative Chest Complications.*
11th	M.	1.00	Dr. BAKER. Clinical Lecture. *Treatment and Aftercare of Acute Myocardial Infarction.*
14th	Th.	1.00	Dr. Ulf RUDE, of the Children's Clinic, Carolinska, Stockholm. *Radiological Aspects of Organic Obstruction to Pulmonary Flow.*
18th	M.	1.00	Mr. BLAIKLEY. Clinical Lecture.
19th	T.	1.00	Mr. ECKHOFF. Clinical Lecture.
20th	W.	2.15	Clinical Theatre. Radiotherapy Tumour Conference. *Testicular Tumours.*
21st	Th.	1.00	Dr. BISHOP. Clinical Lecture. *Modern Methods of Contraception.*
21st	Th.	5.00	Neurosurgical Round. Clinical Theatre. Conducted by Mr. MURRAY FALCONER.
22nd	F.	1.00	Dr. MacLEAN. Clinical Lecture.
23rd	S.	10.00	Clinico-Pathological Meeting. Clinical Theatre.

BILATERAL PARAFFINOMA OF BREASTS

LOCAL MASTECTOMY AND AUGMENTATION MAMMAPLASTY

PATRICK CLARKSON, F.R.C.S.

The following patient, who was referred to me through Mr. R. S. Lawrie, M.S., F.R.C.S., is described as presenting points of importance particularly on two different and difficult problems.

The patient, who is 35 years, without children ten years after marriage, had multiple diffuse chronic granulomata, following injection of paraffin ten years before, in Asia, to improve the contour of her breasts. These injections were followed by the appearance of multiple lumps in the breasts, some of which broke down and discharged. These ill-defined but hard lumps, which were tender and were attached to the skin and muscle layers, caused pain and gross distortion of both nipples. She clearly had "paraffinoma". It was my belief that such a condition, especially in breasts (but also when found around the rectum or in the face), where paraffin had been injected in the past, was pre-malignant, and that there was a strong indication for the excision of the lumps for this reason, as well as for biopsy and symptoms, and sometimes for appearance.

One of the things I learnt from this case in consulting Prof. A. Haddow, of the Institute of Cancer Research, and Dr. Cuthbert Dukes and Dr. Jakubski, of the London Clinic, was that paraffinomas do not become malignant. They are chronic granulomata which do sometimes become grossly infected and break down. Around the rectum, this gross infection may cause difficulty in diagnosis and obstruction of the lumen of the bowel. On the face and breast these lumps can be regarded as an appearance problem only.

The second matter of major interest was that of restoring the mammary prominence by the relatively new Dow Corning medical grade Silastic Prostheses. Silastic can be regarded as a form of rubber and the non-vulcanised clear fluid silastic is contained in an envelope of vulcanised silastic. Dr. Tom Cronin, of Houston, described this prosthesis at the Third International Congress of Plastic Surgery in Washington in 1963, when he stated that the over-riding advantages of these vulcanised silastic sacs containing non-vulcanised silastic fluid, as mammary prostheses compared with the open sponges (such as etheron or polivinal alcohol) are as follows:—

1. They are better tolerated in the tissues.

2. The fact that unlike open sponge prostheses they do not shrink, nor become hard in the tissues.

Case History of the Patient

Diagnosis. Bilateral Paraffinoma of breasts; Bilateral local Mastectomy.
Replacement by Silastic Prostheses.

Age 36 years

History.

First injection of paraffin	1953
First appearance of lumps	1957
Incomplete removal of lumps in Asia	1958

The patient was seen in London on 3rd June, 1964. Following examination the decision was made for surgical treatment to be carried out in one main stage, plus one or more later plastics to the distorted nipples.

8th June at the London Clinic, under General Anaesthetic (Dr. David Carnegie).

1. Local Bilateral Mastectomy of lumps in the breast caused by paraffin injections.
2. Insertion of Silastic Mammary Prostheses.

By the second day post-operatively both breasts were visibly distended with fluid; the left side more than the right.

10th June at the London Clinic under Local Anaesthetic. The lateral 2 ins. of the incisions were re-opened and approximately 3 oz. of dark blood was evacuated from the right breast, and approximately 4 oz. from the left breast. The wounds were resutured. The following day the wound continued to ooze and the decision was made to re-explore the wound under General Anaesthetic.

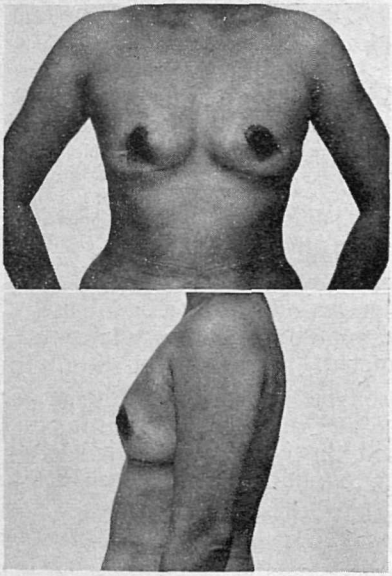

Figure 1. Pre-operative photograph of the patient with deep scars and mutilation of the breasts ten years after the injection of paraffin, "To improve the shape and size of the breasts". The diffuse lumps were superficial and deep.

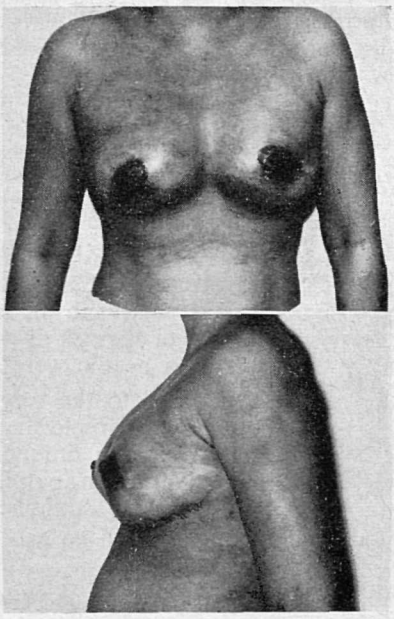

Figure 2. After Bilateral Mastectomy and plastics to nipples and restoration of breast promontory by the insertion of Cronin's Silastic Mammary Protheses.

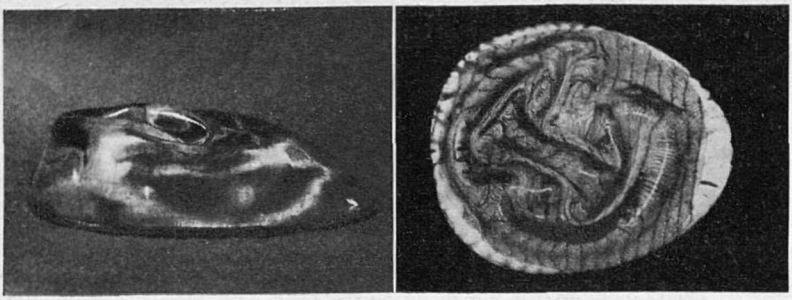

Figure 3. *Cronin's Silastic Mammary Protheses.* These are envelopes of Medical Grade Silastic, which contain fluid silastic. They have a thin backing of Dacron which becomes adherent to the chest wall by ingrowth of granulations. These prostheses are made in three sizes large, medium, and small. They are inserted through a submammary incision. Their consistency is soft throughout ; they undergo no shrinkage, and unlike open sponge prostheses, they neither become hard, nor shrink in size.

12*th June under General Anaesthetic* (*Dr. David Carnegie*). Exploration of wounds; about 3 oz. of fluid from each side was evacuated.

17*th June*. Some sutures were removed.

22*nd June*. Both breasts were re-explored, and about 30 ccs. was evacuated from the right side, and 35 ccs. from the left side.

24*th June*. A superficial aspiration was undertaken, only small amounts were obtained from each side.

27*th June*. The patient was discharged, two weeks and five days following the first stage.

31*st August, at the London Clinic under General Anaesthetic*. Revision of breast, and nipple scars (which dated from the early operation in Asia).

2*nd October, under Local Anaesthetic*. Further revision of nipple scars, and of lateral scar of left breast radiating from nipple. Uneventful healing.

Special Points

The points that are important about this patient are:—

1. The great care that was taken to evacuate any accumulations of fluid present in the early stages. This was done digitally, because of the risk of penetration of the silastic sac, if aspiration by a needle were attempted.
2. In addition to the very reasonable restoration of the breast contour and nipple shape by later revisions, the silastic prostheses remain uniquely soft in consistency and closely approximate, on palpitation, to a normal rather tense breast. It is, however, a little heavy.

Abstract of Report 1958 from Asia

Nature and Site of specimen: Excised breast specimen.

Clinical Diagnosis: Paraffinoma, examination for malignant changes.

Gross Examination: Specimen consists of many firm irregular masses varying from 1½ cms. to 7 cms. In addition, there are two larger masses, each about 10 cms. in main diameter. Among them, two specimens show skin attached to one surface and nothing remarkable. The remaining specimens are composed of fat and tough pale whitish tissue. Sectioning through these tissues reveal

that in some of them tiny cystic areas are seen. In others these tiny cystic areas are plentiful. Careful sectioning grossly reveals no frank areas of malignancy.

Microscopic Examination. Three sections show similar features. There are spaces of varying sizes separated by dense fibrous and hyalinized tissue, at places thin and other places plentiful. In this stroma, there is patchy mononuclear cell infiltration and around some of the cystic spaces there are foreign body giant cells. No sign of malignancy.

Diagnosis: " Paraffinoma " of mammary gland.

Abstract of Pathological Reports and Letters from Dr. Cuthbert Dukes, Prof. A. Haddow and Mr. Jakubski. 1964. (With the kind permission of the above to publish. Their opinion is gratefully acknowledged.)

Professor A. Haddow: "The name *paraffinoma* is used largely to describe any tumour resulting from the injection of any non-absorbable oil. Paraffinomas are never malignant, nor are they in any sense pre-cancerous.

Paraffinomas may be mistaken clinically for malignant neoplasm because they increase in size and appear to be infiltrating and may cause an obstruction: e.g. a paraffinoma of the rectum resulting from the treatment of haemorrhoids by the injection of non-absorbable oil. For this reason they may require surgical treatment.

Paraffinomas have been mistaken by pathologists because the histology has some resemblances to an angioma or what used to be called an endothelioma. The characteristic appearance is that of cystic spaces enclosed by pseudo-epithelium and surrounded by a granulomatous reaction."

Dr. Jakubski: Specimen: Simple resection of tissue from both breasts. The specimen consisted of both breasts by bilateral simple resection. The tissue was rubbery to firm on section. Cut surfaces were yellowish-white and contained multiple microcysts oozing an oily yellowish substance.

Microscopy: The mammary tissue shows extensive fibrosis with resulting atrophy of the glandular elements. This is due to a foreign body reaction to an oily substance which is contained in minute cysts lined by giant cells. There is no evidence of malignant change. The appearances are consistent with a bilateral pariffinoma of the breast.

Summary

A case of bilateral diffuse paraffinoma of both breasts of twelve years standing, following injections of paraffin with later mutilation and formation of multiple granulomata. Treatment by mastectomy and simultaneous breast restoration by Dr. Cronin's silastic mammary prostheses is described.

REFERENCES.

Augmentation Mammaplasty, a new " natural feel prosthesis." T. Cronin, Excerpta Medica Foundation. Transaction of the Third National Congress of Plastic Surgery. Washington, 1964.

SIR THOMAS BROWNE AND DR. JOHNSON:

A COMPARISON

G. L. DAVIES

Whilst meditating upon this subject, and thinking (oblivious of the fact that there is nothing new under the sun) that it would have all the air of originality, I suddenly came across a passage in a book which I happened to be reading which dispelled any illusions as to originality. The book in question was Cyril Connolly's *Enemies of Promise,* where Connolly makes a quotation from that once-eminent literary critic, Edmund Gosse. This is what Gosse says:—"The study of Sir T. Browne encouraged Johnson, and with him a whole school of rhetorical writers in the 18th century, to avoid circumlocution by the invention of superfluous words, learned but pedantic, in which darkness was concentrated without being dispelled." "But to dismiss Johnson's influence," Cyril Connolly goes on to say, "as something altogether deplorable is surely to misunderstand the whole drift of the great revolution which he brought about in English letters . . . Johnson, there can be no doubt, determined to remedy these evils [i.e. the prose style of his day] by giving a new mould to the texture of English prose; and he went back for a model to Sir Thomas Browne. . . . With the *Christian Morals* of Sir Thomas Browne to guide him, Dr. Johnson set about the transformation of the prose of his time. . . . Browne's "brushwork" is certainly unequalled in English literature, except by the very greatest masters of sophisticated art such as Pope and Shakespeare; it is the inspiration of sheer technique."

A hundred years separate Johnson from Browne, not a very long period in the evolution of a language, so that the difference between Browne's prose and that of Johnson's day should not have been so very marked. If one takes the French poet Villon and our own poet Chaucer, both of whom lived round about the year 1400 and, assuming first of all some knowledge of French, it is not so very difficult to construe Villon's poems, and neither is it so difficult to understand Chaucer with occasional reference to the glossary. Why, therefore, should Johnson have to operate so radically on Browne's prose? The answer of course is that Browne deliberately adopted an ornate, archaic style which, one reads, was the cause of his failure to be elected a member of the Royal Society which had set its face against the old elaborate prose with its "amplifications, digressions, and swellings of style".

Apart from any question of prose styles, Browne and Johnson are of interest from the point of view of religion, morals, character and literary abilities. They were both devout Christians: Browne starts off his *Religio Medici* by saying that, though various circum-

stances might persuade to the contrary, "yet, in despight hereof I dare without usurpation assume the honourable stile of a Christian". He looks upon the wonders of Nature as confirming the existence of God: "Thus there are two books from whence I collect my Divinity; besides that written one of God, another of his servant Nature, that universal and publick Manuscript, that lies expans'd unto the eyes of all; those that never saw him in the one have discovered Him in the other." Like Dr. Johnson, however, he has his rationalistic moments, for he adds: "There is, as in Philosophy, so in Divinity, sturdy doubts and boisterous objections, wherewith the unhappiness of our knowledge too nearly acquainteth us. More of these no man hath known than myself, which I confess I conquered, not in a martial posture but on my knees." He complains of lack of unity in the Churches, a subject which seems to have been as topical in his day as it is in ours . . ."particular Churches and Sects usurp the gates of Heaven and turn the key against each other. . . ."

Not only was Johnson a devout member of the Church of England, but he would not allow Christian principles to be flouted or treated lightly in his presence. In this respect he was a noteworthy exception in an age when intellectuals openly scoffed at the Christian faith. All the same he had too keen a sense of the human tragedy for faith to have an easy victory. Besides believing in the efficacy of prayer, he believed in the Bible as genuine revelation; he believed in the reality of free will: " Sir, we know our will is free, and there's an end on it." His prayers to the number of about 100 are still in existence and well repay reading for their deep and earnest sincerity as well as beauty of literary form. They reveal to us his own awareness of his own indolence and his own chronic sense of guilt. One remembers his remark to Garrick that he would go no more behind the scenes at the theatre because his amorous tendencies were too much aroused by the physical charms of the actresses. Sir Thomas Browne, on the other hand, blithely remarks, "I could be content that we might procreate like trees without conjunction, or that there were any way to perpetuate the world without this trivial and vulgar way of union, nor is there anything that will more deject his cool'd imagination, when he shall consider what an odd and unworthy piece of folly he hath committed." Browne had yet to be married when he wrote that; and, in the sequel, left a numerous progeny.

It is interesting to reflect on the character of these two men. One was a doctor of medicine, whilst the other was "the great cham of literature", and a mere "dabbler in physic", as Boswell said. Both, of course, had great literary gifts but for originality of mind one would, I think, hand the palm to Sir Thomas Browne. Johnson was more conventionally-minded. He believed in formalized religion. Man was naturally corrupt, he said, and needed to be continually reminded of his duty. Browne, too, we know, was a regular churchgoer ; but though he was, we gather, an able and popular doctor, we feel that he looks down on humanity from a loftier plane than Johnson, who mixed with people in the market place, so to speak. Johnson never ceased to mourn for his wife, " Tetty ", who died when he was 29,

and he charitably befriended a number of other women for many years. To Browne, however, Man was "the whole world, and the Breath of God, Woman the rib and crooked piece of Man". Even after some years of marriage he speculated curiously on God's purpose in creating Eve as a "helpmeet" to Adam. Browne could talk lightly of death, whereas to Johnson it loomed ever more terrible the older he got. Whilst Johnson for many years, until he received a pension from George III, suffered all the pangs of poverty, Browne seemed to have lived in a state of affluence from his early years. Science had its fascination for both, Browne in the direction of Natural History (which led him to dare dyspepsia or worse in the interests of Science by experimental meals upon spiders and bees) and Johnson in that of chemistry. Both lend themselves very much to quotation, and Browne, strangely enough, even to-day, is more quoted by lay writers than by members of his own profession; which perhaps, after all, is not so surprising as his works are mainly literary productions.

If a final word may be added about these two men it is that, politically, both were Royalists. During the Civil War Browne discreetly minded his own business; but, without having aped the future Vicar of Bray, revealed himself at the Restoration as a partisan of the king. Johnson, without having much respect for George III as a man was, nevertheless, indebted to him for a pension which raised him from a state of poverty to one of comparative affluence. He supported George III in his war against the Americans with his pamphlet "Taxation No Tyranny", and perhaps he only anticipated many people to-day when he said, "I am willing to love all mankind, except an American."

NOTICE

Guy's Hospital Dental School—Travelling Scholarships

NEWLAND-PEDLEY TRAVELLING SCHOLARSHIP.

This Scholarship will be awarded to the holder of a registrable dental qualification, who has been educated at Guy's Hospital Dental School, to enable him or her to undertake a year's postgraduate dental study at an institution abroad approved by the Dental Council. The value of the Scholarship will be up to £1,000, and the actual amount of the award will depend upon whether the holder of the Scholarship proposes to spend a year at an institute in Europe or Scandinavia or whether the year will be spent in Canada or the United States. The holder of the Scholarship may be required to undertake teaching duties in this School for the academic year following that in which the Scholarship is held.

DENTAL TRAVELLING SCHOLARSHIP.

This Scholarship has a value of £250 and is awarded every third year to the holder of a registrable dental qualification, who has been educated at Guy's Hospital Dental School, to enable him or her to study at one or more Colonial or Foreign Dental Schools approved by the Dental Council.

Both these Scholarships will be offered for award in 1965. In order that applications for the Travelling Scholarships may be considered by the Dental Council in sufficient time to enable the successful candidates to make arrangements for travel, etc., it is necessary for all applications for Travelling Scholarships for 1965 to be received by the Dean of Dental Studies by **1st February**, 1965. The Dean of Dental Studies will be pleased to discuss the matter with anybody who is interested.

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"Yes, I'd Like To Come, Too"

AN ARTICLE ORIGINALLY WRITTEN FOR THE SOUTH LONDON PRESS AND GENERAL RELEASE.

When the Evelina Children's Hospital received a legacy from Miss C. E. Goddard, the Medical Committee was asked for its suggestions. There was little doubt among the members as to the major project to which it considered this might be devoted. For several years there has been one cubicle into which a mother could come with her baby whilst it was ill and most in need of her. The doctors wanted more of these cubicles for babies and children.

At one time all visiting was forbidden in some children's wards, on the idea that visitors might bring in new infections. Fifteen years ago, Guy's was the first teaching hospital to have daily visiting in its children's wards. It lead to no increase in infection among the children and the visits kept the children in touch with their families. It had been realised that children under the age of five can suffer a lot if they are separated from their mothers. It may be possible to explain to a four-year-old; it is impossible to explain to a two-year-old why the mother who loves him could go away and leave him alone in a strange place. For a little child to wait till to-morrow may be to wait through an eternity.

With babies of a few months old, the mothers come in partly to help with the care and partly because it can be very sad for a mother not to be able to give her care at the moment when she feels her baby needs her most.

There are many procedures that require the special skill of the children's nurse and in recent years many new procedures have added to the special skills required; the medical care and surgical treatment of children with congenital heart disease is practised in many children's hospitals to-day. The doctors and nurses at the Evelina have devoted special care to saving the lives of babies with heart troubles and even tiny prematures have been operated on with success. This is a remarkable advance, for only a few years ago three out of every four babies born with congenital heart disorder died before they reached the age of a year.

In such cases the mother can give a great deal of help: she adds her own special continuous loving care to the devoted care and skill of the nurses; and in helping with her new baby, the process of getting to know her baby, which every mother goes through in the early months is not interrupted, but is encouraged by the fact that in this crisis, her help is valued by the hospital; she is not shut out to feel useless. The worry that every mother feels when her baby or child is ill will be less if she is able to be doing something to help instead of having to sit at home and wait and wonder.

On October 1st three new cubicles, each of which has a bed for a mother and a cot or small bed for a child, were opened for use. The accommodation is not luxurious. Who would want to live in a bedroom with glass walls?—even if the curtains can be pulled round—" like a goldfish in a bowl " as a mother has put it. But many mothers are glad

of the chance. Some mothers have other small children at home and cannot come. (At Guy's we have sometimes taken a father to help the child through the difficult time of being in hospital and to avoid the additional burden of separation.)

Miss Compton, the Lady Superintendent of Nursing at the Evelina, says about the cubicles: "The Nursing staff are very pleased to have the facilities to accommodate more mothers with their children and, contrary to popular opinion, do not find the arrangement difficult. It is a great help to mother and child for the mother to receive practical guidance, rather than just advice."

We are quite prepared to have father or mother stay, and have already had a nanny with one child.

Since the facilities are limited it is interesting to note that the nursing staff supervision, in many instances, is not lessened by the admission of the mother with her child. It does, however, increase the student nurse's knowledge of the family as a whole and prevents her treating the child as only a patient with a disease.

R.C.M.

Department of Biochemistry and Chemistry

SPECIAL LECTURES IN BIOCHEMISTRY, 1965

MONDAYS

18/1 *Biochemistry and clinical medicine*
J. Butterfield

25/1 *Carbohydrate metabolism and diabetes*
H. Keen

1/2 *Glycogen metabolism*
R. Mahler

8/2 *Oxidative phosphorylation I*
W. N. Aldridge

15/2 *Radioactivity and medicine I*
N. Veall

22/2 *Radioactivity and biochemistry I*
D. B. Gower

1/3 *Phospholipid catabolism*
G. R. Webster

8/3 *Dietary carbohydrates and serum lipids*
I. Macdonald

15/3 *Regulation of cell metabolism I Biochemical aspects*
A. N. Davison

22/3 *Regulation of cell metabolism III Morphogenesis*
N. A. Gregson

FRIDAYS

15/1 *Biochemistry and evolution*
G. A. D. Haslewood

22/1 *Biochemistry and pathology*
R. H. S. Thompson

29/1 *Biochemistry of insulin*
S. Cameron

5/2 *Adipose tissue and NEFA metabolism*
T. Hanley

12/2 *Oxidative phosphorylation II*
W. N. Aldridge

19/2 *Radioactivity and medicine II*
N. Veall

26/2 *Radioactivity & biochemistry II*
D. B. Gower

5/3 *Serum lipids*
R. W. R. Baker

19/3 *Regulation of cell metabolism II Theoretical aspects*
W. L. G. Gent

These Lectures will be held at 4.30 p.m. in the Chemistry Theatre. Although these Lectures are directed to Candidates for the Academic Diploma in General Biochemistry, all interested are invited to attend.

CRITICISM

Guy's Hospital Music Club—December, 1964

"The Creation"

Guy's Hospital has reason to be proud of the Music Club. Last year, for their main work they chose Handel's "Messiah". No other music is so sure to attract a public in this country but the response was remarkable and Southwark Cathedral was not only full, but crowded. That audience had the uncommon experience of hearing the complete work virtually without cuts. The success of that performance was also seen this year when the chosen work was Haydn's "Creation" which, unfortunately, does not have the same public appeal. It would be expected that increasing numbers from the hospital community would be attracted, for the high standard over the last few years could hardly escape notice. That, on Tuesday, 15th December, Southwark Cathedral was once again comfortably filled would indicate that many of last year's public had returned, and that the reputation of Guy's Hospital for successfully presenting large-scale musical works is far from parochial.

There are three good reasons why "The Creation" was a happy choice to follow "The Messiah". First, it was a natural successor in the rapidly enlarging stream of eighteenth century music which ended in the torrent of Beethoven. In 1791, Haydn, then 59, paid the first of his two visits to London which was made possible by the death of his patron Esterhazy, whom he had served for nearly thirty years. Though restricted in orbit by his faithful service as a provincial Kappelmeister, he was of international repute and on this visit he was socially and musically fêted. He was taken to the races at Ascot, visited the astronomer Herschel and his telescope at Slough, and also the surgeon John Hunter of St. George's, who attempted to relieve him of a nasal polypus which was a life-long burden. More important, he heard his first full-scale performance of "The Messiah" in Westminster Abbey and was profoundly moved, exclaiming at the "Hallelujah" chorus—"He is the master of us all". His admiration for Handel and interest in oratorio was strengthened by a second visit to London in 1794. He took back with him to Vienna a text, based on Milton's account of the creation in "Paradise Lost", once intended for Handel, and it was on a German version of this in 1796 he was commissioned to write the work which "The Messiah" had first inspired. It would seem that he felt that "The Creation" was to be his greatest work, for he devoted himself to its composition as to no other of his enormous and varied output, and it was not until 1798 that it was completed, first performed and first acclaimed. This was not another *œuvre d'occasion* but was for posterity, and he surely knew that he had succeeded. In his remaining and declining years he spoke of it with warm and yet humble pride, he conducted performances himself as long as was able, and his last appearance in public a year before his death, aged 77, was when he was carried to hear it.

A second reason for the good choice is the prerogative that amateurs can exercise in tackling great works which are infrequently heard, thus enlarging the musical experience of both performers and their friends. The ears of both were undoubtedly opened by "The Creation". The musical advance from "The Messiah" was at once apparent in the overture representing Chaos, with its sombre, harmonic colour surprising in its modernity; to this ear thoughts of Parsifal in the earlier bars did not seem so romantic when it came to a very

Tristan-like close. Chaos then resolves with the quiet entry of soprano and then chorus and is banished with the sudden fortissimo C major chord on "Light"—a most dramatic and moving stroke of beauty and genius. The narrative of the seven days' wonder is carried by soprano, tenor, and bass soloists in recitative which is far from *secco,* and in solos of delicacy far removed from the old rumbustious *da capo* aria of oratorio, and often Schubertian in their youthful and sinuous vigour. Their presentation of elements, birds, beasts, and finally man is dramatic and vivid. This is finely expressed by Rosemary Hughes in the Master Musician series: "It would require pages of quotation to show how completely musical, throughout the work as in the prelude, are the means by which each descriptive passage makes its point, drawn with the directness and loving precision of Fra Angelico's flowers or Giotto's ox and ass." The choruses have the old vigour of Handelian oratorio, but a new subtlety—witness Haydn's Hallelujahs in "Achieved is the Glorious Work"—and are more exciting by changes in impetus and richer orchestration. Another advance is the concerted use of the soloists, either singly or in trio, with the chorus, an advance which Haydn had used with great effect in his Masses. We soon heard how telling this could be in enhancing "The Heavens are", the best known chorus of the work. There is ample evidence to show that Haydn intended this to be his great work and a masterpiece it certainly is. But it is a gay and jolly work for as always with Haydn as it was with Mr. Edwards in Boswell's Johnson—"I have tried too in my time to be a philosopher; but I don't know how, cheerfulness was always breaking in".

The technical difficulty of "The Creation" is the third good reason for attempting it. To achieve success must have gladdened the hearts of the performers—though we understand these were in incipient failure at the last full rehearsal—and justified their many hours of preparation. Last year was memorable for the assembling by Christopher Gaches of an orchestra of amateur musicians from Guy's and other London hospitals and colleges instead of relying on young professionals as in previous years. "The Creation" is, however, a more taxing orchestral score than "The Messiah". It demanded a full orchestra with doubled parts for woodwind and brass including trombones, and the long passages of descriptive playing as well as colourful accompaniment demands the highest skill. An orchestra of fifty-one players—with a minimum of professional backing in the wind and brass sections—achieved this under the strong leadership of Gaches. The long introduction depicting Morning at the beginning of Part III was particularly memorable in balance and phrasing. The harpsichord continuo of Alan Tyson was emphatic without being obtrusive and the leader of the 'cello section—a notably strong section of the orchestra—produced a fine, mellow phrasing in the figured recitatives. I hope the choir enjoyed themselves in surmounting their difficulties without even minor disaster as much as we enjoyed their lively response and good tone. The balance of the four sections was good though the total volume seemed less than last year. This may well be because of a fuller orchestral texture, and even a choir of well over 100 voices has difficulty in projection when they are placed behind but not above the orchestra, particularly with a high cathedral vault above them. Of many felicitics noted, I hope the tenors and basses were proud of their entries in "Achieved is the Glorious Work" and the sopranos and contraltos for their white, soft tone in "In the beginning". The response to the changes in time and attack of the choir became increasingly assured as the work progressed, being particularly good in the third part, and the time changes in the final chorus were very well achieved. The most perfect conjunction of chorus with orchestra in the evening was in the soprano and bass duet with chorus—"By Thee with Bliss".

The soprano, tenor, and bass soloists were Susan Longfield, Peter Bamber, and Brian Etheridge, who had all given professional support on previous occasions. It is hoped that they understand how much this was appreciated, for the remuneration that could be offered was in inverse ratio to their individual and combined excellence. Together, and with the chorus, they sang with the precision and sympathy of a virtuoso string trio and with tone that was sheer delight. This, of course, would not have been possible without the assurance of the firm control of the total forces behind them given by the conductor. Susan Longfield soared heavenwards with clear, full tone, whether in verdure clad or in bird-song, and we well realised that the voice of Eve we heard at the end began as an Angel. Peter Bamber has a full and natural tenor voice, effortlessly produced, which he used with the greatest delicacy and refinement, particularly well displayed in the accompanied recitative, "In Splendour Bright"; I look forward to hearing him in Opera, which needs a voice like this. Brian Etheridge, showing no sign of the cold from which he was suffering, sang with authority in recitative and warmth in aria and we particularly enjoyed his graphic zoological narrative. An acid test for basses is whether the voice has the flexibility and colour to sing lieder; no litmus was needed here for this is a fine instrument, well used.

The Music Club has a long and distinguished record. It has even had a "First Performance", on May 1st, 1914, when Denis Browne, organist to Guy's Hospital, conducted a very full and varied programme which contained one of his own works. It also included the first London performance of three of Vaughan Williams' "Five English Folk Songs". This was not an isolated visit of the composer to Guy's for later that year he was drafted to the hospital for instruction as an R.A.M.C. recruit. Without doubt, the Club has had lean years, for a musical society is very dependent on the ability and drive of those who direct its activities. There is always the material, for, despite the impression we like to give and transmit to foreigners, we are a musical nation. But some individual person has to kindle the musical fire and the reason it has been burning so brightly in recent years is due primarily to the presence amongst us of a fine musician, Robert Sells. Mention has already been made of the major contribution of Christopher Gaches, and the Club is greatly indebted to the enthusiasm and hard work of its secretary, Peter Peace. Nevertheless, the fine performance of December 15th would have been impossible but for the direction of its conductor. He was always in command of his forces, his decisions on times were masterly, his phrasing and rhythm were impeccable, and the great work flowed lightly, grandly, and without flaw under his beat. The performance in Southwark Cathedral was a great achievement, but the greatest admiration must be for the training that made this possible, or even, as many thought in the early rehearsals, conceivable. Hospital hours and duties present difficulties which could only have been overcome by the sympathy, patience, and inspiration of Robert Sells. As the Reverend A. J. Saint said so aptly in his very successful appeal to the audience to subscribe to the expenses and to UNICEF—he had started with Chaos and achieved the re-Creation of a masterpiece. To him and to his supporters, amateur and professional, our thanks are due, and to the Music Club and the guest performers our congratulations, with a firm request that this sort of thing must continue.

C.G.B.

CORRESPONDENCE

Res Natura at Guy's

SIR, Many Guy's men will have been interested in the notes by Timothy Peet (*Gazette*, December 12th) on the wild life in the vicinity of the hospital. I can recall many floral invaders on the surrounding bomb-sites in the immediate post-war years, including Ragwort, Rosebay, Mallow, Campion, Small-flowered Willowherb, Kew Weed, Melliot and Yellow Toadflax; all long since vanished, I suppose, except the Ragwort. Also, I have nostalgic memories of the kestrel covering above the tower of Hunt's House. But, sir, I was grievously disappointed to find no mention of that oldest coterie of Guy's men, albeit still unqualified after at least half a century of regular attendance, i.e. our starlings.

Their annual autumn conference in the tree tops in the park has left me with ineradicable memories of their vociferous chatter at dusk, to say little of their hazardous excretory habits. Maybe, like myself, they have left their Alma Mater. I sincerely hope not. During my long sojourn at Guy's, I sometimes wondered if a final desertion by the starlings might portend (as in the legend of Gibraltar and its apes), the decline of our hospital. Perhaps, sir, to allay my anxiety, and doubtless that of many other old Guy's men, you will include in one of your next autumn numbers the news of the return of our most faithful adherents.

Yours, etc.,

V. E. LLOYD.

Buckhurst Hill,
Essex.

JOHN EBER SPALDING

Mr. John Spalding M.S. Lond., F.R.C.S., consultant surgeon to the Wrexham Group of Hospitals, died on December 9th, aged 53.

He entered the Medical School at Guy's in 1929, winning the Open Entrance Scholarship in Science. Later he won a Junior Proficiency Prize, the Michael Harris Prize in Anatomy, the Sands Cox Scholarship in Physiology, and in 1934 was awarded the Golding Bird Gold Medal and Scholarship in Bacteriology. After qualification in 1935, he became house surgeon to Mr. E. G. Slesinger; then Demonstrator of Anatomy, and 1937 Surgical Registrar to the late Mr. E. C. Hughes. Later he was Registrar to the late Mr. R. Davies-Colley, and afterwards to Mr. Slesinger. In 1939 he was appointed a surgeon in the Emergency Medical Service, and worked at the County Hospital, Farnborough, until 1945, when he returned to Guy's as Registrar to Sir Heneage Ogilvie.

In 1946, Spalding was appointed consultant surgeon to the Wrexham Hospitals, being the first of a number of Guy's men who came to North Wales after the war to pioneer and develop the hospital services there. His brilliant gifts soon brought him recognition, and he rapidly became a leading medical figure in the area. His surgical skill and judgment were held in high esteem both by his colleagues and by his patients. Moreover, he was an excellent teacher, as many former registrars, housemen and Guy's students will testify. He had a clear mind, despised humbug and hypocrisy, and was devoid of pomposity. Some eccentricities of manner only served to increase the affectionate regard of a large circle of friends. Early and increasing deafness made him shy of committees and of public appearance, but in any matter of importance affecting the Wrexham Hospitals, his opinion carried great weight.

Ill-health forced him to give up work nearly a year ago. By his premature death, North Wales has lost a gifted and dedicated surgeon, who will be hard to replace. Many Guy's men, too, will remember "Sam" Spalding with affection and regret.

He married in 1936 Katherine Davies, a Guy's nurse, who survives him with five children. His eldest daughter Patricia was also, until her marriage, a nurse at Guy's.

REVIEWS

MEDICAL PHARMACOLOGY,

by A. GOTH, M.D. Henry Kimpton. 2nd Edition. 1964. Pp. 585. *Price* 88*s*.

This book is written primarily for medical students and physicians, and its aim is to emphasise principles and concepts rather than the type of factual information which students memorise and promptly forget. To a certain extent, Dr. Goth has succeeded; he has however missed out such a lot that I wonder whether the book will really prove satisfactory. Thus the mode of action of thiazide diuretics is dismissed in nine lines and there is no reference to the fact that the mechanism of action is different from that of mercurials.

There is no mention of a number of important facts which illustrate general principles. Nothing is said about the fate in the body of streptomycin nor of its poor penetration into the C.S.F. There is reference to it being given sometimes twice a week, but no opinion as to whether this is satisfactory. The only toxic action of PAS mentioned is on the stomach. In the section on isoniazid there is no mention of quick and slow inactivation, surely an important new concept. The section on antibiotics is very poor on the new penicillins, and the treatment of aspirin poisoning is quite inadequate. No mention is made of allergic reactions to aspirin or paracetamol. This list is merely illustrative. There is a section on prescription writing which is not very satisfactory for British readers.

If I was limited to one book I would not choose this one, nor would I favour it as a book of reference.

J. ROBSON.

ELEMENTARY PHYSICS,

by G. Stead. 11th Edition. J. and A. Churchill, Ltd. 1964. Pp. 16 + 544.

When a physics textbook has been selling successfully and continuously over a period of forty years, difficulties are liable to be encountered when introducing alterations, since these must be made without destroying the essential character of the book which has commended it to so many students.

In the eleventh edition of this book, Professors Stead and Allsopp have modernised the approach to the teaching of electricity by starting from the concept of the free electron. This is a welcome change and leads more naturally to the understanding of the workings of both valves and transistors than does conventional circuit theory. The inclusion of the transistor is in itself of interest to medical students, with the increasing use of small electronic devices in medicine. Ultrasonics are also given a place in this new edition, although it is a pity that their diagnostic and possible therapeutic uses have not been enlarged upon. The other main modernisation in the book is the chapter on electrolysis, where the short section on concentration cells should serve as a useful introduction to the concept of ion movement in physiological processes.

As with previous editions, this book can be strongly recommended to 1st M.B. students and other students taking physics at A-level who require a non-mathematical approach. One wonders, however, whether there might be a case for actually increasing the mathematical content of the book by including a section on statistics, since there must be few doctors or dentists who would not welcome more knowledge to enable them to discriminate effectively between this or that treatment, or between A or drug B. Perhaps the authors may consider this in a later edition, if they are introducing other modifications, but meanwhile there need be no fears that Stead XI will not prove as successful as the previous editions.

E. H. GRANT.

CELLULAR FINE STRUCTURE. AN INTRODUCTORY STUDENT TEXT AND ATLAS,

by J. A. FREEMAN. McGraw-Hill. pp. 198. *Price* $9.50.

In this book Dr. Freeman aims to introduce the student to the elementary principles of electron microscopy and to equate the light and electron microscope appearances of various tissues. The book is divided into three main parts dealing firstly with the preparative tchniques, then with the different structures shown in the cell, and lastly a variety of tissue cells are demonstrated.

There are some excellent line drawings and three dimensional representations, and the layout of the text makes it easy to read, as Dr. Freeman says, he has limited the account to the essentials. An important feature in an atlas of this kind, however, is the quality and clarity of the electron micrographs. Many of the high power pictures are good, but unfortunately Dr. Freeman's attempt to bridge the gap between the light and electron microscopes with low magnification electron micrographs is not successful. This is due partly to the lack of adequate contrast in his pictures, which is to some extent unavoidable, but mainly to the scarcity and confusing nature of his labelling.

The general standard of tissue preservation is good, though in one or two pictures, especially of nervous tissue, the standard is below that of the majority.

As an introduction, this book is probably adequate, but there are much better atlases on the market at a similar price. There are also inexpensive introductory books on ultrastructure which are illustrated by line drawings, and I think a combination of this with a high standard atlas would be better value.

R. O. WELLER.

PSYCHIATRY.

by E. W. Anderson. Baillière, Tindall and Cox. London. P. 296. *Price* 16*s*.

First impressions of this book are all excellent. The author has chosen to discuss his subject as much as describe it, and this broad approach provides a thoughtful and stimulating introduction to psychiatry. Thus psychopathology and the psychiatric examination are discussed in some detail, which makes easier reading of the rest of the book. Although some will disagree with the author's classification of psychiatric conditions, specific conditions are well described. Remarks on aetiology and diagnosis are of particular interest and usefulness, respectively. The discursive element in the text shows to bad effect in sections on treatment, which are rather too vague to be helpful to the student; the notes on treatment in chapters on specific conditions are particularly at fault. Rather brief chapters on legal aspects and child psychiatry are included. Despite the overall lucidity of the text, there are some irritating lapses in syntax which should not survive this edition. Otherwise, this book has many points to commend it, besides its convenient size, low price and pleasant format.

BRENDAN HICKS.

NOTICE

Pupils' Physical Society

A symposium on *BURNS* will be held at 5.0 p.m. on Tuesday 12th January, in the Surgical Demonstration Room. The speakers are as follows:

For General Surgery—Mr. Gazet.
For Plastic Surgery—Mr. Richards.
For Paediatric Psychiatry—Dr. O'Keefe.
For Pathology—Dr. Mant.

All Students are invited to attend this symposium and also to come to our next meeting, a *Clinical Evening* with the London Hospital, on 2nd February, at 5.30 p.m. Finally, we should like to remind those interested in preparing papers that the Beddard and Laidlaw Prize Competition is held in March.

MICHAEL D'SOUZA.

SPORT

RUGBY FOOTBALL

GUY'S v. EXETER

At H.O.P. 28th November, 1964

Result: lost 13—17

It was a fine, cold, windless afternoon when Exeter kicked off towards the pavilion end 15 minutes early, at 2.30 p.m. Your correspondent, who had had the considerable satisfaction of watching the previous two games against Aberavon and Buckinghamshire County R.F.C., when Guy's surpassed themselves in the standard of their play, was looking forward to a rousing consolidation of their present form, but in this he was due for disappointment. Early play was scrappy, neither side settling down to play either basic or entertaining football. In almost the first full blooded movement by Guy's after 20 minutes, however, Rowlands went over to score, but had his try disallowed. From the ensuing five yard scrum, however, Bevan was around the open side to score close to the posts. Morris made no mistake with the conversion (5—0).

Exeter retaliated immediately, and an infringement on their own line by Guy's gave them a penalty wide out which was converted (5—3). Just before half-time, another Guy's infringement in a line-out gave the opposition a further difficult penalty attempt which was accepted (5—6).

At the changeover, the only person on either side who was out of breath was probably the referee, whose piercing use of the whistle was a feature of the game throughout. Guy's were playing less open rugby than of late and were paying the penalty by being down at this time. It had now turned very cold, and vocal support from a large contingent of Guy's supporters in the stand diminished as they began to concentrate their energies on keeping warm.

The second half began in a similar scrappy way to the first, before play settled on Guy's line for a time. Then, from a quick heel and superb passing along their threequarter line, Exeter put their outside centre over for a good try, which was unconverted (5—9).

Exeter continued to press until Morris, whose touch-kicking had sparkled from the start, made one of his few mistakes. An abortive kick for touch was misfielded, and the entire Guy's back row, with help from Ross on the wing, were up on the loose ball. Ross found himself in possession and broke superbly along the touch-line. His short kick over the full-back was rapidly followed up and the ensuing scramble ended with Rowlands, appearing from nowhere, going over in the corner. A good effort at the conversion by Morris failed by inches (8—9).

Exeter then increased their lead through a further penalty, well kicked from just short of half way by their full-back, who also played a sterling game throughout. With the scent of victory in their nostrils, Exeter began to play better football, and they were aided in this by an almost incessant supply of the ball from the tight. Guy's seemed to have lost what little cohesion they had in the pack, and only the efforts of Brown (K) and Cockburn in the line-outs maintained their interest in the set-pieces. We were due for a surprise, however, when a badly placed Exeter diagonal kick saw Bundred in possession a few yards from his own line. He made ground along the right wing and cross-kicked before he had reached half-way. The ball bounced kindly for Cockburn, coming through the middle at great speed. His pass to Sharp was well timed and similarly a further pass to Ross left the winger with nobody to beat on his way to the line. He sensibly grounded the ball between the posts, and Morris's kick gave Guy's the lead at 13—12.

Exeter were not to be outdone however, and eight minutes from time bad marking by Guy's let in the No. 8 forward from Exeter to score close to the posts. The conversion finished the scoring for the day at 13—17.

Apart from the moments when the points were scored, the game was disappointing as a whole. Guy's failed to play as a team and thus did not deserve to win. Their supporters will hope that this loss of form is only temporary and that they will soon regain their winning ways.

DEREK BIGGS

BOAT CLUB

UNIVERSITY OF LONDON WINTER VIIIs

December 5th.

The same crew who had such success in the U.H. regatta the previous week, entered the U.L. regatta confident of putting up a good performance. This was duly achieved, although not without narrowly escaping disqualification for the late arrival of one of the crew.

The first round was won easily against St. Thomas's in excellent conditions, and the crew repeated this in the second round against Imperial College "A" crew. In the final, Guy's met a confident University College crew, the latter having given good performances in their heats.

After a start rating 40, Guy's held U.C. to Chiswick Bridge, and here a spurt by the latter gave them half a length. This was held by Guy's, expecting to row through U.C. However, this was not achieved and despite an excellent finish, U.C. held on to their half length lead. This was by far the best race of the season so far, and Guy's are to be congratulated for a controlled and polished row.

Crew—Bow: P. Sharp. 2: J. Grimble. 3: D. Jessett. 4: P. Burton. 5: A. Hodgkinson. 6: P. Telling. 7: G. Stygal. Stroke: M. Preece (Capt.). Cox: A. Green.

A. GREEN

The Past Term

As can be seen from the reports, Guy's have made great strides forward as a rowing power in the University. This has been due largely to the efforts of M. A. Preece as captain, and to the welcome addition of two outstanding freshers, J. Grimble and G. Stygal. The 1st VIII must be congratulated for their keenness and work. The Novices and Junior IV have had some setbacks to their training, but under J. Williams next term, the fusion of these should produce an excellent 2nd VIII.

The new boat and new blades have been ordered from the builders, the blades being spades which should add speed to the crew in the Heads next term.

The term ended with the Dinner, held at the "Grapes" on the 10th December. The President, Mr. Manzie, and Vice-Presidents, Mr. F. Law and Mr. D. Gurney, were present, and other guests included Mr. D. Cooper and Dr. H. Freeman, the latter adding weight to his presence with some excellent anecdotes.

BOXING

GUY'S v. TRINITY COLLEGE, DUBLIN

7th December, 1964

This was a successful evening for Guy's at the University gymnasium. The small team virtually represented London University who were acting as official hosts to the Dubliners.

The first bout, between welterweights T. Gibson (Guy's) and R. London (Trinity), started slowly. Gibson moved away from the swinging Irishman and set the pattern for the first two rounds. There were numerous exchanges in the third, but the earlier defensive attitude of Gibson earned London's victory.

A second welterweight match between P. Leopard (Guy's) and J. Hodson (Trinity) was fought with tactics similar to the first. However, in this case Leopard's defence proved too much of a problem for his opponent. The Guy's man not only contained Hodson's attacks but was able to score with skill and some venom; particularly in the last round. In this way Leopard fought his way to a deserved victory.

A. Craig (Guy's) gave an admirable display in an exhibition bout against C. Hagan (Belsize). Craig's fortitude sustained him in a gruelling and truly entertaining match against a taller and more experienced man. Much of the rounds were devoid of skill and their exhibition value this somewhat lowered. However, the energy involved in this clash warmed the crowd to expectations fulfilled in the next.

K. Hughes (Guy's) fought J. Love (Trinity) in a featherweight competition which provided a large store of action. In the first round, Hughes exhibited a confident aggression and soon cornered his man with several well aimed punches to head and body. The second round was more even as Love fought back with determination and scored intelligently at times. In the last round Hughes reasserted his position and inflicted many telling blows on a wearied opponent. This victory also went to Guy's. In all, an evening when the art was often displayed but rarely with nobility.

FIXTURES

We would like to draw your attention to the Rugby Fixture List which appeared in the Gazette of 26th December, on page 617, owing to pressure of space in the Sports Section.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Senior Registrar in the Neurological Department,** with duties commencing on 1st March, 1965. Application forms are obtainable from, and should be returned to, The Superintendent, Guy's Hospital, London, S.E.1, not later than **23rd January, 1965.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the appointment of **Full-Time Registrar in the Department of Conservative Dental Surgery** with duties to commence as soon as possible. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, London, S.E.1, not later than **Monday, 18th January, 1965.**

GUY'S-MAUDSLEY NEUROSURGICAL UNIT

Applications are invited for the **Resident Post of Senior House Officer** for the six months commencing 1st March, 1965. The Unit, which is housed in the Maudsley Hospital, serves both Guy's Hospital and the Bethlem Royal Hospital and the Maudsley Hospital. Applications should be made by **16th January, 1965,** to L. H. W. Paine, House Governor and Secretary, Maudsley Hospital, Denmark Hill, London, S.E.5.

HOUSE APPOINTMENTS

GUY'S HOSPITAL, S.E.1.

March 1st, 1965

Applications are invited for the following House Appointments at Guy's Hospital, due to begin on March 1st, 1965, applications giving choice of post and choice of hospital, in order of preference, to be lodged with the Superintendent, not later than **January 29th, 1965.**

Assistant House Surgeons
Pre-registration 4
The appointment will be for six months, the first three to be spent as A.H.S. During the second three months of the appointment candidates will move either to the post of Casualty Officer (Surgical) or will remain as A.H.S.

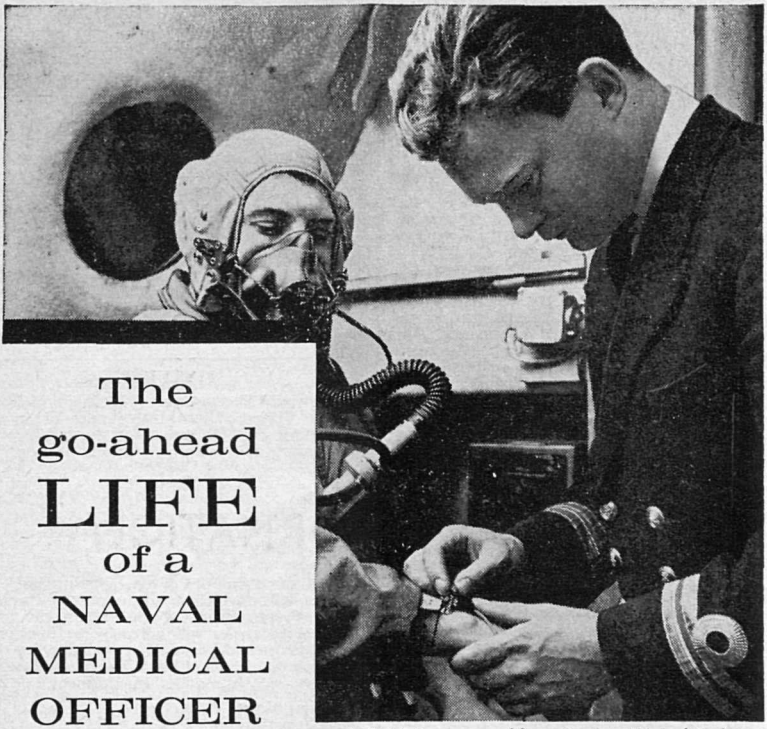
These vacancies will normally be open only to pre-registration candidates applying for their first appointment and not to candidates seeking their second six months appointment.

Assistant House Physicians
Pre-registration 5
The appointment will be for six months, the first three to be spent as A.H.P. During the second three months of the appointment candidates will move either to the post of Casualty Officer (Medical) or will remain as A.H.P.

These vacancies will normally be open only to pre-registration candidates applying for their first appointment and not to candidates seeking their second six months appointment.

Casualty Officers
Pre-registration 6
House Surgeons
1 Pre-registration
1 Pre- or post-registration 2
House Physicians
1 Pre-registration
1 Pre- or post-registration 2
***Resident Obstetrician**
Post-registration 1
***Gynaecological House Surgeon**
Post-registration 1
Throat and Ear House Surgeon
Pre- or Post-registration 1
Neurological House Physician
Post-registration 1
House Surgeon to the Thoracic Unit
S.H.O. 1
Children's House Physician
Pre-registration 1
(2nd six months candidate only)
House Physician in Clinical Pathology
S.H.O. 1
House Physician to Dr. Bishop, Dr. Wayte, and Mr. McArthur
Pre-registration 1
House Physicians in the Department of Psychological Medicine
S.H.O. 2
To commence on 1.4.65.

The go-ahead LIFE of a NAVAL MEDICAL OFFICER



A pilot being prepared for a simulated high altitude test.

This is a life of unbounded opportunity. Anywhere in the world, you practise medicine with complete medical freedom. Among 100,000 Naval men and women you gain extensive medical experience of the most varied nature. Civilian patients, too, of both sexes and all ages, are treated in Naval hospitals. You have excellent opportunities for specialising in the normal clinical subjects, and in the less usual, such as Nuclear, Underwater, and Aviation medicine. You are actively encouraged and financially assisted to acquire higher degrees. You can gain consultant status.

As a Medical Officer, your pay, allowances, and gratuity—or permanent commission pension—are very good: for example, your initial pay is considerably higher than that of a civilian hospital registrar.

You can enter in one of three ways: as a registered Medical Practitioner — your civilian experience back-dating seniority— or as a qualified doctor doing your pre-registration year, or as a student with a 2nd M.B. For qualified women doctors, there is a special short service commission. For fullest details of your Royal Navy life as a Medical Officer, write, mentioning your own qualifications and age to:

The Medical Director-General of the Navy, Medical Dept. GO66/G, Empress State Building, London, S.W.6.

R.M.O. in Nuffield House
S.H.O. 1

Resident Anaesthetists
1 S.H.O.
1 Post-registration 2

*From March 1st, 1965, there will be two resident obstetric posts consisting of obstetrics only. These are recognised by the Royal College of Obstetricians and Gynaecologists for training for both the "Membership" and the "Diploma in Obstetrics" Examinations. All the gynaecological duties will be the responsibility of a gynaecological house surgeon, now advertised. At the moment this is a post-registration post only, as such it is recognised for training for the "Membership".

The Medical Committee will also consider applications for posts at outer hospitals as follows:—

HITHER GREEN HOSPITAL

House Physician in General Medicine and Infectious Diseases
Pre-registration 1
To commence 7.3.65.

JOYCE GREEN HOSPITAL

House Physician
Pre-registration 1
House Surgeon
Pre-registration 1

LEWISHAM HOSPITAL

House Surgeon to Mr. Cavendish
Pre-registration 1
House Surgeon to Mr. Le Brun
Pre-registration 1

NEW CROSS HOSPITAL

Senior House Officer in Medicine and Geriatrics
S.H.O. 1

ORPINGTON HOSPITAL

House Physician
Pre-registration 1
House Surgeon with Orthopaedics
Pre-registration 1
To commence 1.4.65.
House Surgeon with Physical Medicine
Pre-registration 1
To commence 1.4.65.

QUEEN MARY'S HOSPITAL, SIDCUP

House Surgeon
Pre-registration 1
House Physician
Pre-registration 1

ST. JOHN'S HOSPITAL, LEWISHAM

Casualty Officer and Orthopaedic House Surgeon
Pre-registration 1

ST. OLAVE'S HOSPITAL

Senior House Officer in Medicine
S.H.O. 1
To commence 1.4.65.

NOTICE FOR PRE-REGISTRATION CANDIDATES

Pre-registration candidates are reminded that the number of posts at Guy's is small compared with the number of students who are likely to qualify. Students applying at Guy's, therefore, are advised to consider applying for pre-registration posts elsewhere at the same time, in order to avoid delay in obtaining a post. A number of recognised posts is available in the South-East Region. Details of posts in this region and elsewhere in the country are available in the Medical School Office.

*Pre-registration candidates who have completed six months in Medical or Surgical posts are reminded that they must now apply for Surgical and Medical posts respectively. A candidate who has completed his first six months in a specialty (Surgical or Medical) may not do another six months in a specialty, but must seek a post in general medicine or general surgery as the case may be, according to G.M.C. regulations.

J. B. BLAIKLEY,
Superintendent.

AWARDS

GUY'S HOSPITAL DENTAL SCHOOL

Prize in General Subjects, November, 1964

First Prize—P. R. Mewton

PASS LIST

ROYAL COLLEGE OF SURGEONS OF ENGLAND

Final F.R.C.S., December, 1964

M. K. Dunstan — C. E. A. Holden
W. G. Hartfall — E. R. Walrond
K. E. Hobbs

UNIVERSITY OF OXFORD

B.M.

T. M. B. Jenkinson* — A. L. W. F. Eddleston*

UNIVERSITY OF CAMBRIDGE

Final M.B., Part 1

D. R. Bevan — G. A. Pettitt
T. J. R. Bruce — B. S. Ricketts
Elizabeth A. Cosgrove — J. D. Rogers
D. J. Ewing — A. R. M. Upton
K. E. Haynes — N. W. D. Walshaw
A. M. Morris — G. F. Wearne

*Completed the examination

PERSONAL

Dental Surgeon practising in the City would like to meet another Dental Surgeon in the London area to discuss the possibility of an amalgamation. Box No. 602.

CHANGE OF ADDRESS

Mrs. Nigel Curtis-Raleigh (Dr. Jean Steadman), 9, Wetherby Gardens, S.W.5. Telephone FRE. 1670.

ENGAGEMENT

Mr. M. A. Nelson, F.R.C.S., to Miss Diana Freedman.

BIRTHS

MEMBREY.—On November 24th, 1964, at 10, Linden Gardens, Tunbridge Wells, to Priscilla (née Atkinson) and Tony Membrey, a son, a brother for David, James and Sophie.

MARRIAGES

CURTIS-RALEIGH—STEADMAN.—On 23rd December, 1964, at Westminster Cathedral, Nigel Curtis-Raleigh, B.A., Barrister-at-Law, to Jean Steadman, M.B., B.S.

NURSING WITH THE ROYAL NAVY

NURSING SISTER

Requirements for Direct Entry as a Nursing Sister are British Nationality, S.R.N. with at least one year's post-graduate experience. Preference given to applicants with an extra qualification. Nursing Sisters serve in Royal Naval Hospitals and in Royal Naval Sick Quarters at home and abroad and with the Fleet Air Arm. There are opportunities overseas for Midwifery and District work. Special allowances and Seniority given to Sister Tutors.

For further details on the Queen Alexandra's Royal Naval Nursing Service write to:—

The Medical Director General (Naval), Empress State Building, London, S.W.6

GUY'S HOSPITAL GAZETTE

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Editors *B. H. Hicks*
P. Bowden

Sports Correspondent *N. J. Knott*

Guy's Hospital, London

PASSIM

Schism

Perhaps we are too old-fashioned. Perhaps our ideas on Medicine are much too Hippocratic for some. But we believe there are certain demands upon professional men that cannot easily be snubbed. Teachers do not exact their vengeance upon their pupils' education. Doctors do not squeeze governments by neglect of their patients.

The question is raised by recent statements of the Medical Practitioners' Union, which talk of possible "withdrawal of services", and a circular to their members asking if they would support such withdrawal of N.H.S. facilities to men between the ages of 21 and 60. When negotiations are yet in progress both on the amount and method of remuneration for the family doctor, and when many groups are discussing the future form of general practice, it is difficult to see what—even in a political sense—such threats could achieve. Their futility is increased by the fact that four out of five family doctors are not members of the M.P.U. At present the only possible effect of such remarks is a loss of public sympathy and a hindrance of negotiation.

Looking beyond "the threat" to its execution, more than politics is involved. If no patient was going to suffer by this "limited withdrawal", if one were absolutely sure of this, then our objections would be over-ruled. There is no such certainty, however, in a population accustomed to N.H.S. Medicine. Indeed, if they did not suffer, would not the withdrawal be, politically, a failure? When the withdrawal is over, "success" or failure, the public view of the doctor will be irreparably damaged, the private doctor/patient relationship dealt another blow. This cannot be the aim of the M.P.U. if they really have the good of family doctoring at heart. Either they have not, or they have made a mistake. No doubt future events will show us which the case may be.

The Old Order

In two months the *Gazette* will have achieved two thousand editions and although it has seen many changes, few have been radical, it remains unique in purpose and function. Around us, however, most change is evident as the face of Bermondsey and Southwark receives a lift, but, throughout it all, London Bridge Station remains isolated and derelict, facing the hospital like a film set of Decrepitude.

The shops have been demolished in the Approach and constructors are delving deep to give ample support to the flyover being built from London Bridge to the Station. The barrows are clustered in colourful chaos outside the tube, the cobbles are being torn up and the old man at the end still sells rotten bananas. Where will all the flowers go?

On the other side of the Thames, behind Billingsgate, giant office blocks are being built—they look like forced asparagus tips of pale, cultivated concrete. Nearer home the old Miller is fast becoming a heap of rubble although memories and a tap-room smell still linger; psychiatric out-patients, stark and forbidding, is all that remains of the north side of Snowsfields. Between Kipling Street and Weston Street and overlooked by the Leather Market, the land is bare and flat, the terraced houses are gone, to be replaced by better things.

Further south, at Elephant and Castle, the greatest change is to be seen. Gone are the Irish and the public houses and in their stead is a misplaced Ministry of Health block and a number of towers clustered round the central junction, whose axis is a dimpled aluminium creature of doubtful purpose. The buildings all round seem like monolithic seaside hotels closed for winter; gone is the chaos and the character. Houses are being replaced by offices and people are retiring nightly into anonymity. On Sundays the only people to be seen are visitors and students who think it's Saturday still.

Dr. Donald Vaughan, of Cromer, Norfolk, has been awarded the gold badge of the Royal National Lifeboat Institution for his exceptional work in this service. He has served both as President and acting member of the lifeboat crew—when a doctor was needed. We were delighted to hear of this unusual distinction.

The Sisters' Dinner is one of those traditional affairs that never deserve the contempt bred of familiarity. This year's Dinner ably maintained a reputation of congenial informality, a spice of freshness in the new faces and a touch of nostalgia in the old. The guest of honour, Mr. Gibberd, was in as merry mood as Mine Hostess, and the company enjoyed their words to a background of pleasant candlelight and a superb repast. May every Dinner be as good.

GUY'S DIARY

JANUARY		
26th T.	1.00	Mr. BLACKBURN. Clinical Lecture. Anatomical Theatre. *A Journey in Egypt.*
28th Th.	1.00	Dr. H. A. CONSTABLE, Secretary to the Medical Protection Society. Clinical Lecture. Anatomical Theatre. *Medicine and the Law.*
29th F.	1.00	Dr. KAUNTZE. Clinical Lecture. *Thyrotoxicosis.*
FEBRUARY		
1st M.	1.00	Dr. STAFFORD CLARK. Clinical Lecture. *What Freud Really Said.*
2nd T.	5.00	Recent Films of Medical Interest. Anatomy Theatre.
4th Th.	1.00	Mr. LAWRIE. Clinical Lecture.

THE COLD BABY

NEONATAL HYPOTHERMIA DUE TO COLD EXPOSURE

TREVOR P. MANN

Royal Alexandra Hospital for Sick Children, Brighton

There are a number of possible causes of hypothermia in the neonate but exposure to cold should be regarded as the most important aetiological factor in the British Isles to-day [1, 2, 3]. The cases of this kind we see in practice can, with advantage, be considered under two headings. Firstly, there are those babies in which the duration of cold exposure and of hypothermia has been relatively short (i.e. less than six hours). Secondly, we have the much larger group of cases where the chilling has been prolonged; here the resulting disturbance is much more profound and because of biochemical and other changes successful treatment may be a formidable task. I shall refer to the first disorder as **acute neonatal hypothermia** and to the second as **neonatal cold injury.** As we shall see, the majority of babies in the first group are easy enough to identify. Here the chilling takes place immediately after birth and, although occasionally accidental, is for the most part due to negligence. In the second group of infants we are dealing, generally speaking, with an insidious affection and because of the baby's deceptive appearance, recognition of the hypothermia as well as of the nature and cause of the disturbance, may be delayed.

DIAGNOSIS

Most of the cold babies we see have been born at home. Acute hypothermia may arise at any time of the year, whereas neonatal cold injury tends to occur in the winter months when the weather is severe. Our experience in Brighton has been that the majority of babies with acute hypothermia are illegitimate ones and the three we have treated in recent years have all been delivered, unassisted, by the mother herself. Occasionally one hears of a baby being set aside and left in cold surroundings (the bathroom at home or the sluice in hospital) immediately after delivery because it is considered to be still-born and only later found to be breathing and by then severely hypothermic. Badly asphyxiated babies may chill easily, especially whilst being resuscitated, and then show a profound temperature drop whether being treated in the home or at hospital.

The usual story one gets in cases of *cold injury* is that the baby made satisfactory initial progress after a normal spontaneous delivery in the home, the pregnancy having been uneventful. Occasionally we learn that asphyxia complicated the birth or that the infant showed signs in the early days suggestive of intra-cranial injury. Although the baby may be a little smaller than average, prematurity has not been an important contributing factor as one might have expected. At some point in the first week or so of life, possibly a little later, increasing apathy appears, and this causes concern when the infant first takes insufficient milk and then shortly afterwards refuses all feeds. Swelling of the extremities, particularly the hands and feet, as well as other parts such as the eye-lids, may first lead to concern about the baby's well-being. Coldness to touch is sometimes noticed early on by the mother, perhaps when the baby is put to the breast. Other less constant presenting features may be related to a haemorrhagic tendency or to impaired kidney function. Thus, blood may be vomited or passed per rectum, or decreasing amounts of urine may be voided until micturition ceases altogether.

On arrival at hospital the body temperature is usually well below 90°F. (32.2°C.). Although apparently conscious these infants lie noticeably still. The facial expression is serene and does not suggest ill health; on stimulation the infant may show some response by furrowing the brow and a whimper or feeble whine may be heard. The skin feels remarkably cold and corpse-like, especially over the extremities; there is an aura of coldness about the baby when a hand is placed under the clothes or cot coverings. Redness of the skin, affecting the face, hands and feet is a striking and constant finding, usually with a particularly high colouring of the eyebrows, cheeks, nose-tip and chin. Occasionally skin pallor may be found but still the infant does not look ill.

Pitting oedema of at least the extremities is common and on careful examination it may be found to be widespread. At some stage, usually not until rewarming is in progress, localised hardening of the skin and superficial tissues overlying oedematous parts may be apparent. This change commonly starts in the distal parts of the legs and then may spread to involve the trunk, finally affecting most of the body surface. Its appearance usually indicates a poor prognosis.

The recognition of *acute neonatal hypothermia* is relatively straightforward; here, in the majority of instances, the chilled state is self-evident even to the untutored eye. In contradistinction, realisation that the baby with cold injury is severely chilled and dangerously ill may be long delayed. This oversight on the part of doctors and nurses is often due to the paradoxical facial erythema which, with the slight oedema, gives the majority of these babies a misleading appearance of well-being. It is also due to the strong aversion of most midwives to temperature recording in the newborn.

AETIOLOGY

Not infrequently, babies suffering from cold injury show signs of infection, if not on admission then after rewarming, and there has been a tendency to assume that such sepsis is the cause of both the illness and the hypothermia. It is, of course, recognized that an infective process in the newborn may paradoxically cause a fall of body temperature even in a warm environment and doubtless when there is co-existing cold exposure then severe hypothermia may result. However, there are good reasons for believing that chilling alone plays the predominant rôle in the production of cold injury. This conviction is based on a number of considerations:—

1. There is often a close association between the timing of cases on one hand and unusually severe weather and a cold home on the other. Affected neonates tend to present shortly after a sudden fall in outside temperature to freezing point or below [1, 4].

2. The syndrome often occurs in the complete absence of clinical and autopsy evidence of infection.

3. The syndrome does not arise as a complication of the varied infections which are so prevalent in the newborn nurseries of maternity departments. Only one abortive example of cold injury has occurred in our hospitals in the last twelve years, and this was due to a newly delivered baby becoming chilled on a cold June night after the steam heating had been turned off in one of the nurseries.

4. The infections associated with this syndrome are to some extent stereotyped, suggesting that they are a complication of cold injury rather than the cause. Thus, both in the cases we have seen in Brighton and in the series reported from abroad by Nassau[5], rhinitis has been a notable feature. In contrast, nasal infections are infrequent among the smouldering staphylococcal cross-infection to which neonatal units are prone.

5. Our trans-Atlantic colleagues rarely seem to see cases of cold injury although they are not denied their fair share of neonatal sepsis. As Jones pointed out[6], this is probably due to the larger number of hospital confinements and the greater use of central heating in the home.

Certain factors will predispose a baby to chilling in a cold environment. For instance, we have seen that an infection may do this. Similarly, asphyxia, intra-cranial birth injury and severe congenital heart disease, especially left-sided defects such as inactive left ventricle, may render a baby more susceptible to cold. Prematurity, however, seems to play a small part perhaps because there has for long been a general awareness of the relative thermo-lability of these small babies.

TREATMENT

Therapy may be considered under three headings.

Rewarming. Although infants stand up to cooling much better than adults, it seems likely that rewarming deaths, especially after prolonged chilling, will continue to be a problem as in animal work[8]. The trouble is that many of the babies with cold injury seem to be irreversibly damaged by the time they reach hospital.

In adults suffering from acute hypothermia where the period of cold exposure has been short, there seems to be little doubt that active (rapid) rewarming in a water-bath gives, on the whole, satisfactory results[9]. In recent years we have treated in this way three neonates with severe acute hypothermia (admission temperature being respectively 72.4°F., 79.3°F. and 82°F.) and all survived. However, it is equally true to say that when neonatal hypothermia is very recent in origin (i.e. such as one sees after severe asphyxia) rewarming can be achieved quickly and uneventfully simply by placing the baby in a thoroughly warm environment such as is provided by an incubator with an ambient temperature of around 90°F.

The best method of treating patients subjected to prolonged cooling is another matter and is still disputed. There is general agreement that half-hearted rewarming is to be avoided because this may lead to a further steep fall in rectal temperature which in an already severely chilled individual may precipitate cardiac arrest[9]. This phenomenon was observed at the beginning of resuscitation in a three hour old neonate who had recently suffered live-burial in the front garden of the house where she had been delivered by the mother, a young unmarried teenager. Here the initial rectal temperature was 79.3°F. but over the next five minutes this dropped to 77°F. as the body surface was being sponged with water at 88°F. to remove soil from the many skin abrasions which followed life-saving disinterment by the family's faithful dog[13]. Moderate rewarming is, therefore, contraindicated and the choice lies between active (rapid) rewarming and passive (slow) rewarming [9, 10, 11]. At the moment, slow rewarming is favoured for babies with cold injury [1, 2, 3], but it is only true to say that this choice is based on clinical impression and not on a carefully controlled comparison of the two methods. Slow rewarming is best carried out by obviating heat loss and by allowing the infant to warm up through the processes of metabolism. The infant can be nursed in an incubator with the circulating air temperature maintained a degree or so above the average skin reading. Alternatively, and probably just as effective, the infant may be nursed normally clad in a cot at a room temperature of 75-80°F.

Feeding. Important metabolic changes take place during body cooling and have a bearing on resuscitation. Thus, the blood sugar level can show extreme variations according to the speed with which the body temperature is lowered and the duration of the hypothermia. In human subjects, as well as in animals, hyperglycaemia has been reported during rapid cooling[12]. This interesting

phenomenon, together with glycosuria, was described by Claude Bernard as long ago as 1855 in animals cooled to a body temperature of about 68°F. by immersion in iced water[12]. It was observed during the resuscitation of the baby described above who had been buried alive. Here a blood sugar reading of 170 mg% was obtained shortly after arrival at hospital, when the rectal temperature was 79.3°F.[13].

In contrast to the hyperglycaemia of acute hypothermia, hypoglycaemia may occur with gradual body cooling, both in man and animals, [9, 10, 14]. In babies with cold injury, blood sugar levels of less than 10 mg% have been recorded[3], and doubtless by the time readings of this order are obtained the baby's glycogen stores will have been seriously depleted. Accordingly, there seems to be a good case for giving glucose whilst rewarming is in progress, whether or not the pre-treatment blood sugar is critically low. Even in acute neonatal hypothermia where a diametrically different situation may arise as regards the blood sugar level, considerable inroads may have been made into glycogen reserves by the time rewarming is commenced. Here, too, an eye must be kept on the blood sugar trend during treatment and early feeding would appear to be indicated, if not during rewarming then not long afterwards.

A practical problem which arises with cold injured babies is to get adequate amounts of nutrients into them. Theoretical considerations founded on the infant's basal energy requirements[9] and on the need for rewarming and replenishing the glycogen deficit, suggest that a baby of average birth weight will require initially about 50g. of glucose daily. The difficulty is to give this amount intravenously as a 5% infusion, without overloading the circulation. It is true that 15% glucose solution may be given by the intra-gastric route, but although absorption seems satisfactory, such therapy is not without risk because regurgitation and aspiration of a solution of this strength into the respiratory tract may lead to pulmonary oedema. A way round some of these obstacles may be found by using 10-20% fructose (laevulose) in place of glucose. The advantage of this carbohydrate over glucose is that much stronger solutions can be given intravenously without damaging the vascular intima and causing thrombophlebitis. More calories can thereby be provided by this route in a smaller volume of fluid. Also this substance is probably less irritant to the lungs if a spill-over occurs during intragastric infusion.

Drugs. As an infective process may be difficult to recognize initially and because septic complications often become manifest during or after rewarming, antibiotic therapy should be started without delay in cases of cold injury. Little is known about the absorption of such drugs from the alimentary tract in hypothermia and parenteral treatment would seem advisable until rewarming is well under way. A broad spectrum antibiotic should be used. Similar treatment would be indicated in acute neonatal hypothermia especially where chilling follows self-delivery by the mother, or severe asphyxia.

Steroid therapy has been advocated by some workers but is not without danger, even with antibiotic cover, because of the baby's unusual susceptibility to infection in cold injury[3].

Hypothermia prolongs the action of certain drugs and because of this effect phenobarbitone and other barbiturates should be administered with great caution. If convulsions occur the possibility of hypoglycaemia must not be overlooked.

PREVENTION

Acute Neonatal Hypothermia. For obvious reasons preventive measures have little to contribute here. Care must be taken, of course, to protect the asphyxiated infant from becoming severely hypothermic, especially during such procedures as intubation of the larynx and positive pressure insufflation.

Neonatal Cold Injury. There can be no doubt that this condition is largely preventable and that with a wider appreciation of the dangers of chilling in the home, its incidence will decline further. Those concerned with domiciliary midwifery, including the parents, must be alert to the risk of exposing young infants to cold. Newly-born babies need constant warmth, day and night. A point which requires special emphasis is that fatal damage can occur in a thermal environment of 55-60°F., a range which in this country would be considered by many to be comfortable in a living room.

In winter, certain elementary prophylactic measures are called for in domiciliary practice. First and foremost, the temperature of the room where the baby is to be born and nursed should not be allowed to drop below 65°F. in the early neonatal period. This means that wall thermometers should be provided on which the minimal safe level is clearly marked. These should be placed in or near the cot and not on the mantelpiece. Parents should be told what action to take if the room temperature falls below the critical level. It is important for them to be vigilant at night when air temperatures tend to fall and coal fires, often the only source of heat, burn low or go out. They should also be advised to think twice before switching off electric or gas fires last thing at night as is the normal custom.

Careful appraisal of the home before delivery by midwives and health visitors should play an important part in prevention. If heating appliances are considered inadequate, bearing in mind the expected date of arrival of the baby, then there is no alternative to recommending delivery in hospital, unless some type of safe, portable heating equipment can be loaned for the confinement and the early neonatal period.

A second and simple means of prophylaxis is the recording of the baby's temperature at least once a day for the first 14 days. A low reading thermometer (85-110°F.) must be used. If a reading of 95°F. or lower is obtained in the rectum, the midwife should seek

immediate medical advice. A third precautionary measure, which cannot be over-emphasised, is that routine baths should be omitted immediately after birth and during the early days of life, unless the surroundings are thoroughly warm (70° F., or more).

In recent years concerted efforts have been made in East Sussex to prevent the occurrence of neonatal cold injury. As a result there has been a dramatic decline in the incidence of this disturbance and last winter will be remembered at the Children's Hospital because, for the first time for many years, examples of this condition were conspicuous by their absence.

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OBITUARY

HENRY J. HOBY

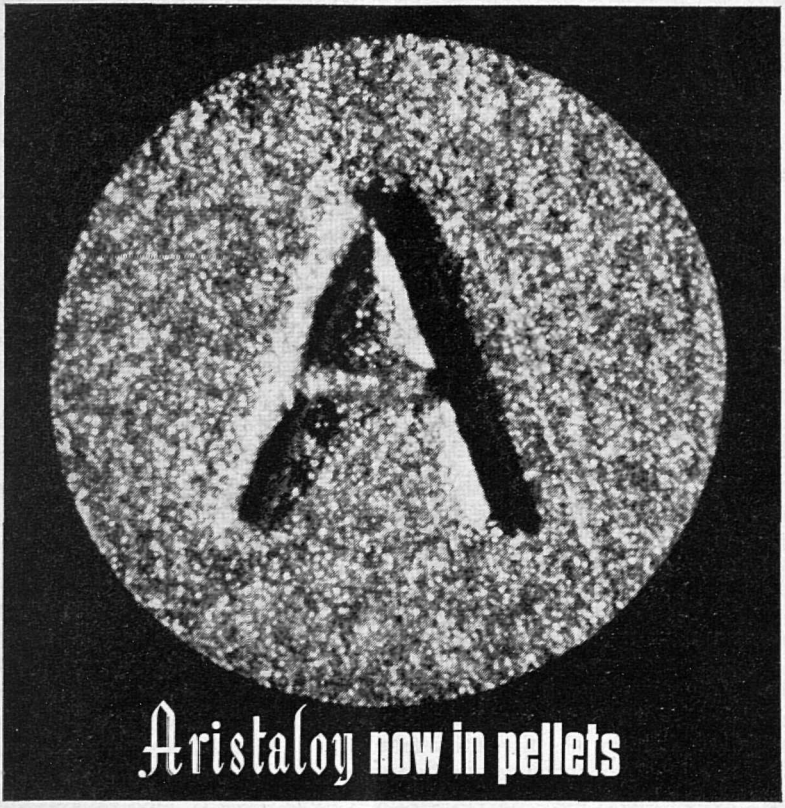
Dr. Harry Hoby, a leading general practitioner in Chatham, died at his home on 15th November, 1964, at the age of 77.

Harry James Hoby was born on 26th August, 1887, in Wellington, New Zealand, and was educated at Wellington College and Dunedin University. He came to Guy's in 1907 and qualified M.R.C.S., L.R.C.P. in 1912.

A fine rugby player, he represented the hospital from 1908 to 1912 and also played many seasons for the Kent County fifteen. After holding appointments at Guy's and St. John's, Lewisham, he entered general practice firstly in Norwich, but in 1914 came to Chatham where he continued in practice for fifty years until a few months before he died.

He was a very active member of the B.M.A., serving as Chairman of the Rochester and Gillingham Division for two long periods. He was an ideal general practitioner, keeping up to date with all modern trends in medicine, but it was as counsellor and friend to all his patients that he was mainly loved and will be most missed. He was a regular attendant at the biennial dinners where his contemporaries always received a warm welcome and by whom he will be missed.

He is survived by his wife and son, to whom their sympathy is extended.



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ASPECTS of DANISH MEDICINE

Peter Gill and Qudus Jamil

Last September we had the opportunity to spend some time in the University town of Aarhus, which has a population of 120,000. Aarhus is the capital town of Jutland, which is one of the two major islands of Denmark. It accommodates the University, with 4,000 students studying all faculties in and two hospitals controlled by the Aarhus Municipality.

The Kommune hospital, founded 1896, is the larger and accommodates over a thousand beds, of which 400 are surgical. We were attached to Professor N. Blixenkrone-Moller, Head of the Department of Surgery. Here we found interesting deviations from the English system in the combination of General Surgery and Gynaecology under our chief, who had two assistant Heads, one registrar and a team of surgeons. The Urology Department similarly incorporates in itself extremities and fractures. The Department also runs an artificial kidney unit.

The Thoracic Department is separately run by Professor T. Sondergaard, who is in addition the Dean of the Faculty of Medicine. He has developed his own ingenious technique for circumclusion of atrial septal defects (closed method).

Aarhus Kommune hospital is a University Teaching Hospital which attracts patients from the whole of Jutland, and each six months about 40 Volunteers, our equivalent of medical students, are obliged to attend. The Volunteers attend a course of three months each in surgery and medicine. Each month they are attached to a different surgeon, and have to follow him in all his duties from 8.0 a.m. to 12.0 mid-day. The Volunteers do not wholeheartedly approve of this system as by the time they get to know the surgeon, they are transferred to another surgeon. They are allowed to do little, but the keener students link up with the Research and Experimental Departments, where the Surgical staff find time to carry out research programmes. Facilities for experimental work are good. Projects in progress in experimental surgery, are among others, studies of gastric cooling for ulcers and studies of the blood pressure produced after experimental coarctation.

After completing six months at the Aarhus Kommune Hospital, the clinical studies continue for another $3\frac{1}{2}$ years—these consist of eight terms of about three months' duration each, when the students attend lectures, seminars and obligatory study of one month in Psychiatry, Paediatrics, Obstetrics and Gynaecology and Ambulatorium (where patients are seen and investigated before admission into hospital). The rest of the time is usually spent in hospital jobs throughout Scandinavia as doctors' reliefs, because there is an acute shortage of doctors and the pay averages 2,000 kr. (£100) per month. Each year there are a few who take jobs in Germany and other European countries, but the pay is not as good as in Sweden. The money earned outside the term time helps towards their keep during the term. The University charges no fees, but a fair number of the students are married and have their wives

looking after them during term time, but on qualifying the house surgeon is paid Kr. 3500 (£175) per month.

The students, before commencing their four years of clinical studies, have to pass Part I in Anatomy, Physiology, Biochemistry and Chemistry. The first part is completed in 2½ to 4 years, hence, to qualify in Denmark takes 6½ to 8 years. The final examination consists of 13 written and oral parts. The maximum mark is +16, and the lowest mark is —22, in each part the candidate's score is recorded on the qualifying certificate. The pass mark is 65, but the candidates have to satisfy the examiners in every part of the final examination.

Our visit to Denmark was completed by visiting the showpiece of the Danish Medical world, their most modern Hospital, the Copenhagen County Hospital at Glostrop, a suburban area of Copenhagen.

This ultra-modern hospital, costing £8 million, having the same number of beds as New Guy's House, is certainly a more expensive version, without there being much material gain in function as a hospital. The Glostrop hospital has been built on the basis of " no expense spared." The decor and the equipment are excellent. They buy the very best equipment in the world, although this does not seem to advance their results and conclusions. The wards are divided into side-wards, the largest for six patients, the smallest for one patient; but it was felt that this produced less efficiency in the nursing of the patients.

The outstanding feature of this hospital is its "egg shaped" operating theatres. The oval shaped roof, containing 64 small, fixed-focus lights, are arranged hemispherically around the operating table. This results in a very small theatre. The main advantage is that the lights can be switched on at elective operative sites during surgery, and this lighting system does give better all-round illumination. This system is expensive and its advantage is debated.

It was a delight to see such magnificent buildings and equipment, and this hospital is well worth a visit to ascertain what other countries are doing in the way of modern hospital planning and building.

Our sincere thanks are due to Professor N. Blixenkrone-Moller, M.D., Over-kirug M. Ottsen, Dr. Hans. A. Svane, M.D., and many other members of the Kommune hospital, staff and students, for providing us a most enjoyable and stimulating month. We are grateful to Professor W. J. H. Butterfield for making this trip possible.

'59 Club Dinner

The Annual Reunion of this Club will be held on March 6th at the Mostyn Hotel, Portman Street, London, W.1, at 7.30 p.m. for 8 p.m. Applications and donations (£2 2s. 0d. per head) should be forwarded to the Secretary.

M. J. S. Coe,
46, Elm Road, Chessington, Surrey. *Hon. Sec.*

Past and Present Boxing Club Dinner

This year's Dinner will be held at the Pillbox, Westminster Bridge Road, S.E.1, on Friday, 5th March, the day previous to dental clinical meeting. All those wishing to attend should contact W. Sheeran, 262, Portland Road, S.E.25.

W. M. Sheeran.

Minoan Medicine, First in Europe

C. P. W. WARREN

Europe's first civilisation was Greek and this, in the eyes of that Golden Age of Greece, the Renaissance to the 20th century, was its greatest. To many, Greece is classical Greece, which is usually considered to start with the First Olympiad in 776 B.C. Its medicine is characterised by Epidaurus, Cos and Hippocrates. Of the preceding ages of Greek medicine little is known. The wounds of the Homeric epics have been analysed by such authors as Fröhlich; the origins of the Asclepius cult have also been fully reviewed. But neither of these throw much light on the medicine of the Mycenean era (1600—1100 B.C.) from whose period they originate. Before the Myceneans was the Minoan civilisation of Crete, and it is their medical practice with which this article deals.

Crete, geographically part of Europe, was the home of the Minoan nation (2500—1400 B.C.). Its people came from the Middle East in Neolithic times (6000 B.C.) but they developed a culture divorced from that of their origins. Crete was the land where the legends of the Minateur, Ariadne and Theseus arose, and which combined with partial archaeological confirmation, led to the writing of that recent best seller, "The King Must Die". The Minoans were a seafaring race who reached a high standard in their art, architecture and government. Their main centre was Knossos, whose excavation was the lifework of Sir Arthur Evans. Lesser palaces have been explored at Phaistos and Mallia; a town has been excavated at Gournia, as well as dwellings and farms at many small sites. Many beautiful vases, statuettes and frescoes have been found, and trade in these was conducted with such places as Egypt. Their language, the Linear B script, which they share with the Myceneans, has been shown to be Greek by Ventris. In 1400 B.C. the Minoan civilisation ended suddenly in unknown catastrophe.

Minoan medicine can be considered from several aspects. Surprisingly, the British, who pioneered Minoan archaeology, have neglected its medicine apart from an article in the B.M.J., 1903. Recently there have been two reviews on the Continent. The most important feature of Minoan medicine is the high level attempted in sanitation. To this may be added a few facts gleaned from interpretation of statuettes, Linear B tablets, and two Egyptian papyri.

A recent correspondent in the *Tatler* remarked on "a profound indifference as to what the Minoans did with their drains". Certainly the guides are exhaustive on the subject, but as Sir Arthur Evans

wrote: "the palace had a system of drainage superior to that of any ancient civilisation; superior indeed to that of any medieval city." Captain Clarke, who visited Crete during the British administration, noted that the Minoans were far ahead of the Modern Cretan, whose sanitation was in a parlous state. This was a period when British plumbing led the world and the *Spectator* could write: " the plain truth is that care for sanitation is one of the last teachings of wisdom that reach the civilised". The British discovery of a civilisation which applied the principles England had only recently learned from the Broad Street pump, led to over-enthusiastic evaluation of the effectiveness of Minoan sanitation.

The Rockefeller survey of Crete in 1948 found that malaria, typhoid and dysentery were among the most common diseases. Water is their common vector and its clean supply and adequate disposal are essential to health. The population of Minoan Knossos has been estimated at 100,000. Their diseases were probably the same as those of 1948 and the drainage system of the palace must have played a part in the well-being of the inhabitants in so large a community.

The palace of Knossos is a sprawl of flat roofed buildings situated over a mound on the west side of the valley of the river Karaitos. The palace is built around open courts. Its lower storeys are lit by light wells. The main drainage system is under the domestic quarters to the east of the central court. A large conduit was laid below the lowest storey. It flows in two directions from its highest point, describes an oval course, reunites and passes as a common effluent down to the river. This conduit was 1 by $\frac{1}{2}$ metre in cross-section, made of stone and lined with cement. At four places large shafts descended to it from higher storeys; these shafts would supply rainwater, drain the roof, and help ventilation. Rain also entered it from the light wells. In one of the upper floors a small "housemaid's closet" enabled rubbish to be thrown into a shaft. Near the Queen's room is the celebrated water-closet. This is a chamber, 2 by 1 metres, with a hole communicating with the conduit in the floor at the room's inner end. Provision was made for a wooden seat as shown by the grooves in the gypsum walls. At the front end of the room a hole in the floor enabled water to be thrown down for flushing purposes. The "pan" at the back was curiously shaped and this may have been for the attachment of a flap valve to exclude sewer gas or to support an earthenware basin.

The idea that the drains of the palace were continuously flushed by running water seems ludicrous when one sees the dryness of the surrounding countryside. Their cleaning must have been manual, their size enabling easy access. Of course, these conditions of drainage cannot have existed for the common folk and, as Hutchinson remarks, the only comment one can make for them is that of the French officer who, criticised for the lack of latrines in his camp, replied, not unreasonably, " mais, monsieur, nous avons toute la campagne". Such is the state of the modern village of Knossos, despite a modern bus service and two jukeboxes.

At the North Eastern bastion of the palace is a winding staircase alongside which is a small open drain, into which the rain flows. It is led down in a series of little steps to check its speed and prevent spillage at the corners. At the bottom it runs through two basins, where the sediment can settle and clean water flow on. Sir Arthur Evans suggested this may have been the palace laundry. The men wore only loincloths and the ladies were décolleté (as was pointed out through most of last summer) but the small and infrequent water supply here cannot have been sufficient for their washing. Nearby, in the court of the stonespout, rainwater was collected into a storage tank; in most areas of the palace it just flowed away.

Bathing was a luxury in which the Minoans indulged. Sunken rooms, lined with gypsum, were at first thought to be baths and called lustral areas. Their appearance is suitable for the splendour of a Hollywood spectacle; their gypsum walls are water soluble and precludes this use of them. They were probably of religious function and Nilson suggests they were snakepits. The Minoans used terracotta bath tubs of modern design. One tub at Knossos has a groove which the imaginative observer sees as provided for the sponge rail. At the Caravanserai the proximity of the bath tubs and charcoal deposits implies hot baths. Here there is also a footbath for the weary traveller and a basin for animals. The Caravanserai was the rest house at the end of the road from the Messara to Knossos.

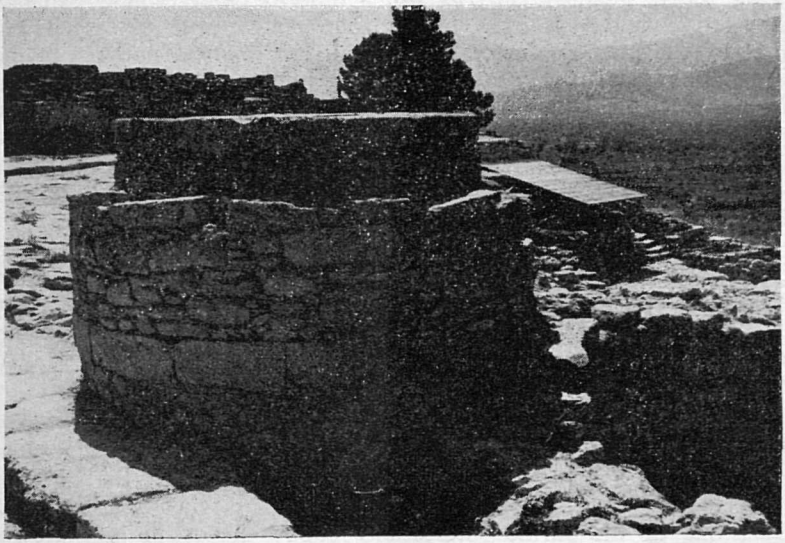
The main unsolved problem of Knossos is the water supply. The river is dry nearly all the summer and anyway received the palace's sewage. Wells have been found at Neolithic levels (their water is still drinkable) but none seem to have supplied the palace. Water must have been needed in large quantities if the drains were to work; let alone for the normal needs of the palace. Rain was certainly insufficient even allowing for change of climate and the great forests of Minoan Crete.

The only spring was to the south of the palace, over the Vlychia ravine. This is in a spring chamber near the Caravanserai. It was connected by a viaduct across the ravine to the palace. Pendlebury thinks this was probably an aqueduct; but due to the contours of the land the Minoans would have had to know that water will flow uphill to its own level and reach the palace. Waterpipes nearby do lead uphill but this may be an artefact following an earthquake. The waterpipes are of very high standard, being made of terracotta ware; the best examples being found in the Corridor of the Draughtboard. They are 70 cms. long, tapered, fitting by socket and spigot joint, waterproofed by cement. A cement bed was prepared for their course. There has been little change in design for 3,000 years. It is possible that springs may have been more numerous in prehistoric times and been destroyed by earthquakes.

At Phaistos, a palace situated high above the fertile Messara valley in the south of the island, there is no extensive drainage system. However, there is a complicated arrangement for the collection and storage of rainwater. The large open courts are laid so that water

flows across them into gutters and is channelled to large cisterns; usually flask-shaped with round well-heads. There is provision for overflow of the cisterns, the water then being led by conduits under the corridors to further storage tanks. Lustral areas are found at Phaistos. Drainage was probably easy since refuse, as is done to-day, could be tipped over the edge of the hill. The nearby summer palace of Aghia Triada shows no evidence of water conservation being close to an everflowing river. It does have extensive stone drains.

Pournapolous, in his article on Minoan Medicine, points out that laws on public health do not change from generation to generation. At Gortyns, a Hellenistic site in Crete, a number of public laws are inscribed on a wall. They were probably Minoan in origin. Willetts has studied them and the first one deals with water supply. People were stopped draining too much from the headwaters of rivers, from using water carelessly and contaminating it.



Above : *Cistern at Phaistos.* **Below :** *Drainpipe, The Corridor of The Draughtboard.*

In 1931, Stubbs wrote: "if it were possible to interpret the Minoan texts we should doubtless find matters of medical interest which would throw light on later Greek developments". Pendlebury felt that the Linear B tablets were probably only palace inventories but did not think them Greek. Ventris and Chadwick's work shows them to be Greek, and palace records. At Knossos, some tablets bear such names of herbs as Coriander, Cyprus grass and date palms. At Pylos, Mycenean, not Minoan, ointments are mentioned and at Mycenae other drugs. At Pylos, tablet Eq 146, bears the word i-ja-te, which Chadwick translates as physician. It is in a land-owning, not a medical, context and Palmer, in his recent work, feels it means only landowner, not physician. Hein in his recent article has summarised the Linear B tablets in a medical context; they throw little light on contemporary medicine.

In Egypt, two papyri of medical interest refer to Crete. The first is the Ebers medical papyrus which describes purges and explains that senna pods are like "beans from Crete", still an important Cretan produce. The second is the London Medical papyrus in the British Museum. It is mainly mumbo jumbo but this may be an Egyptian scribe's attempt at Linear B. A recent German translation may be rendered "Exorcism of the Asiatic sickness in the Cretan language (then follows an unintelligible magic spell); this spell is uttered over; ferment, gas, fluid, urine. . ." It is thought to deal with eye disease.

Pendlebury points out, citing as examples the clay statuettes from Petsofas (2000 B.C.), that the men in Cretan have thin waists and wear only a codpiece and belt, the latter drawn very tight. "It is possible that the thick padded codpiece was necessary as a primitive truss, for violent effort with an artificially constricted waist is very productive of rupture".

At Petsofas, in a shrine devoted to healing, a series of clay models representing parts of the body were found. These are common in antiquity and are afflicted limbs and organs offered by the sufferer; arms, leg, two "hemiplegias" and one "quadriplegia" are seen. At Gazi one of the shrine statues has poppy heads in her crown. Pournapolous feels opium was probably known, used and worshipped.

The Phaistos disk, a round tablet inscribed with hieroglyphs has been "translated" into many languages, including Basque. It has been suggested that it is a medical text similar to an Etruscan disk. As this has not been translated either, the medical connections of both are shaky. Davis feels the Phaistos disk is probably Phoenician and certainly not medical. The snake features a great deal in Minoan culture, but in a domestic role, not the more medical one it attains under Asclepuis.

This article deals with the first period of European medicine. The civilisation was the Minoan—gay, healthful, sanitary, salubrious, as Henry Miller calls it. Their drains and the Queen's lavatory are classics of medical history—Pertinax in the B.M.J. quoting them only recently, for instance. But as is so often in archaeology, and medicine,

a few facts with a good imagination give good theories. To archaeology as to detection, Sherlock Holmes's words apply, "detection is, or ought to be, an exact science and should be treated in the same cold and unemotional manner", or as Hippocrates wrote, "In medicine one must pay attention not to plausible theorising but to experience and reason together—I agree that theorising is to be approved provided that it is based on facts, and systematically makes its deductions from what is observed".

KEY REFERENCES.

ARTICLES.

Prehistoric Sanitation in Crete—Captain T. H. M. Clarke. B.M.J. 1903.
Medicine in Crete—G. K. Pournapolous. Academica Medica. 1957.
The Significance of Linear B in Medicine—W. H. Hein. Pharm. Zeitung. 1961.
Prehistoric town planning in Crete—R. W. Hutchinson. Town planning Review. 1950.

BOOKS.

The Palace of Knossos—Sir Arthur Evans.
The Archaeology of Crete—J. S. Pendlebury.
Documents in Mycenean Greek—Ventris and Chadwick.
Sixty Centuries of Health and Physick—Blaxland Stubbs and Blyn.

The Staff Nurses and Staff Midwives' Dinner

The evening began with a welcome from the gracious personage of the Matron and cocktails were served. Following the Provost's blessing, a meal of remarkable excellence was served. From the prawn cocktails through Consommé Brunoise, through roast chicken (with generous measures of a very suitable Graves), through Christmas pudding, " no fluid in it, you know, only beer and stout and eggs and spirits " and brandy butter, the replete company arrived at an attractive selection of dessert, petit fours, coffee, drambuie and apricot brandy.

Matron then gave an elegant and witty speech and toasted the guests. The guests in their turn were delighted that Dr. MacLean had " thought he really ought to", and accordingly replied with the abandon and gaiety expected.

More coffee outside, and by this time the thoroughly appreciative audience were more than ready for Peter Inward's irreverent but very polished party of entertainers—no doubt about the most popular guest—and thus, apart from a few revellers in a nearby bar, the evening ended. J.D.

Annual Dental Clinical Meeting

The Annual Dental Clinical Meeting will be held in the Dental Department on Saturday, 6th March, 1965, and the Dental Society Dinner will be held in the evening. A resumé of the programme will be published in the *Gazette* on the 20th February, 1965.

Guy's Hospital Music Club

The Annual General Meeting of the Music Club will be held in the Physiology Theatre on Thursday, 28th January, 1965, at 1.00 p.m. All those who have performed in recent concerts are urged to come and help plan the Club's future.

PETER PEACE (Hon. Sec.)

Pupils' Physical Society

There will be a *Quiz and Clinical evening* on Thursday, 4th February, at 5.30 p.m. in the Surgical Demonstration Room.

All clinical students are urged to come and to compete in the quiz, which is being compiled by David Masters.

CORRESPONDENCE

Paraffinoma

SIR, The injection of liquid paraffin or like material into the female breast in a misguided attempt to improve its contour has in recent years enjoyed a vogue in parts of Asia. Its inadvisability has been made amply clear by Mr. Clarkson in his account (January 9th) of a patient with resultant mammary granulomata and discharging sinuses, whom he was able to treat with signal success.

It may interest some of your readers to know that this practice has been attended by other and more serious complications. Tinckler and Stock (1955-56) reported four such cases from Hong Kong: two had received injections of liquid paraffin, one of paraffin wax and one of unspecified wax. The woman given paraffin wax developed bilateral paraffinomata and discharging sinuses ultimately treated by simple mastectomy. In two patients who received respectively liquid paraffin and unidentified wax the inoculum gradually tracked downwards through the superficial fascia of the anterior abdominal wall, finally reaching the labia majora in the former instance.

The most dire results, however, were seen in the second woman injected with liquid paraffin. She lost consciousness four hours after injection, dying later of oil embolism.

Yours, etc.,

G. A. K. MISSEN.

Department of Pathology,
Guy's Hospital Medical School.

REFERENCE:

Tinckler, L. F., and Stock, F. E. (1955-56) Austral. N. Zealand J. Surg., **25**, 142.

Guy, Ghouls and Gold

SIR, In the current exhibition at the Royal Academy of English paintings from the collection of Mr. and Mrs. Mellon, there are two very unflattering portraits of Thomas Guy. The first shows him in the attitude of the conventional miser, clutching his gold, and the other shows him on his deathbed with some sort of devil flying around, waiting to take him off.

Is there anything in the history of our founder to warrant such portraits, or is it perhaps a contemporary reaction to the source of his wealth?

Perhaps others of your readers who have also seen these pictures would like to comment.

Yours, etc.,

J. LEWIN.

46, King Street,
King's Lynn, Norfolk.

The Residents' Play

SIR, May I through the courtesy of your pages announce this year's Residents' Play. The play is entitled "1965, or Experimental Animal Farm", and will take place in the Physiology Theatre from Monday, 22nd February, to Friday, 26th February.

Applications for tickets should be made as soon as possible to myself or the House Manager, Mr. P. K. D. Bush. Donations towards the high cost of production will be greatly appreciated.

Junior Nursing Staff and Students are particularly invited to the Dress Rehearsal on Sunday, February 21st.

The closing date for application for tickets is Monday, 15th February, and owing to the high demand early application is advisable.

Yours, etc.,

P. BANKS,
President of the Residents.

SPORT

RUGBY FOOTBALL

Two games have been played since Christmas, and Guy's has lost both, but on each occasion the team has played well, and a feature of both games was Guy's solid defence.

In the first, Richmond won 15—8, a game in which the margin might well have been smaller but for the mighty boot of Harvey, the Cambridge Blue, who kicked three penalties. Guy's were leading 5—3 at half-time, after a good try in which the scrum half, Bevan, broke on the blind side of a set scrum, drew the defence, and gave it to the wing, Kerner, who scored. It was converted by Morris, who later kicked a penalty. However, after half-time, Richmond had it their own way for a time, and scored two tries, and despite a spirited comeback by Guy's, they were unable to score again. We did not have our fair share of the ball from the set scrums, but Kingdom and Cockburn had a very even tussle with their opposite numbers in the line out.

Last week, Plymouth beat Guy's by a dropped goal to nothing. Against a heavier pack, Guy's did not get enough possession, but again the defence was sound and the line was not crossed. On half a dozen occasions, Guy's were very close to scoring, but failed to do so because of a thoughtless action. If Guy's are to win the Cup, then they must make sure of their scoring chances, for in Cup games, which are dominated by kicking, set pieces and solid defence, chances come very infrequently.

Guy's, who had a bye in the first round of the Cup, will play their first game against Charing Cross on Tuesday, February 2nd. This year, the first two rounds are being played on neutral grounds, and this will be played at the London ground at Hale End.

ASSOCIATION FOOTBALL

Guy's have played only one game since the New Year. In very heavy conditions, they beat Lancing Old Boys 3—2. This annual fixture again proved to be very entertaining, and in this game, W. Davies, the captain, returned to the side after an absence of seven weeks, through injury.

Seven men played for the United Hospitals last Wednesday, losing 3—1 to the Stock Exchange. Those playing were Parry, Elias, Cochrane, Davies, Atkins, Powell-Jackson and Cutler.

Guy's play U.C.H. in the quarter-finals of the Cup on Wednesday. Incidentally, they have already beaten U.C.H. 10—1 this season. On Saturday, Guy's meet Queen Elizabeth College in the quarter-finals of the University of London Cup.

HOCKEY

The team has lost a game and drawn a game since Christmas. This is inconsistent with the results before Christmas, when only three games were lost, and it seems that whenever there is a regular player missing from the forward line, Guy's lose. This is possibly due to a temperamental forward line, but is probably due to a lack of experienced reserves. However, Appleby, the main goal scorer this season, who has been out of the team for some time because of injury, has returned to the side, and thus Guy's field a full side for the first time for six weeks. This is encouraging, as Guy's play Bart's in the second round of the Hospitals Cup, on Wednesday, 20th January.

In the first game, a considerably weakened Guy's side drew 1—1 with Southgate. Against weak opposition, Guy's never really got going, but it served as a warm up after the break over Christmas.

Old Beccehamians beat Guy's 3—0 in a game which Guy's never looked like winning. The defence, who are not used to having many goals scored against them, conceded three, and the forwards, although presented with chances, failed to take them. The result was very fair but Guy's could easily have made it a closer game.

RUGBY FOOTBALL

GUY'S v. RICHMOND

Richmond. Saturday, 2nd January, 1965

Result: lost 15—8

The new year had a fine, sunny day to offer for Guy's visit to Richmond. The ground was firm after recent frosts, but the sun had softened it sufficiently to produce near perfect conditions. Richmond showed immediately that they intended to play a fast, open attacking game, to which Guy's responded in like vein with the limited amount of the ball they received. Richmond dominated the tight scrums where a lamentable performance by the Guy's front row against a theoretically weakened opposition, ensured them an almost free possession. Once gained, the ball was not lightly lost and Richmond were always prepared to change direction and back each other up until a scoring opportunity presented itself. In the first half these tactics produced spectacle rather than points, due partly to handling errors which Guy's were slow to exploit and which Richmond were good to cover, and partly to misfortune. Later, however, Richmond were rewarded with two fine tries. Guy's, with less of the ball throughout, were generally less ambitious but made less mistakes, and with stout defence were able to keep Richmond honourably at bay, and score themselves a fine goal.

Richmond in fact had to be content with mere penalties to lead 6—5 at half-time. Harvey opened the score with a powerful penalty from far out after about fifteen minutes, which the post was good enough to guide home at the end of a lofty, uncertain flight. Guy's replied almost immediately, when from forty yards out the front row won a ball with the head, Brown took it in the back row giving Bevan room to put Kerner away on a powerful, thrusting run down the touchline, which embarrassed several "would be" Richmond tacklers and resulted in a try near the posts which Morris converted.

Richmond continued to air the ball delightfully and were unlucky to be penalised when Guy's collapsing scrum frustrated their efforts to "push over" a five yard scrum. This followed Bundred being caught after he crossed his line trying to relieve the dangerous situation which developed as a high kick ahead was put down near Guy's line. A second Harvey penalty gave Richmond the satisfaction of leading at half-time—albeit tryless.

Richmond quickly achieved a powerful but short lasting supremacy in the second half. Within minutes another "push-over" had almost succeeded, and a glorious movement, which seemed to involve the whole side and most of the playing area, was rewarded with a try and a lead of four points. Both sides now attacked with equal vigour and determination, and Richmond were unlucky to lose the services of Charteris, their open-side wing forward, with a serious knee injury. The home side increased their tally with a goal—their centre making a good break and then just managing to avoid Morris' tackle to score by the posts.

Morris and Harvey subsequently kicked further penalties as the remaining time was played out, both sides still playing hard, open, and to the spectators, enjoyable rugby.

D. J. HENDRICK

HOCKEY

GUY'S v. OLD BECCEHAMIANS

At H.O.P. 9th January, 1965.

Result: lost 0—3

The prospect of several experienced players leaving the 1st XI next season should prompt the younger members of the Club to make their presence felt now. This game was their opportunity to shine, with Appleby and Carruthers absent from the forward line, but instead they failed miserably.

The Old Beccehamian defence must have found it all too easy to beat the "polite" Guy's forwards, who time after time presented the ball to their opponents. Only Liddiard showed any intelligence in the front line and his courageous tackling deserved much praise.

All three goals came in the first half, and while there was considerable doubt as to the validity of the second goal, Guy's never looked like pulling the game out of the fire.

Old Beccehamians were faster and made some of the Guy's players look as though they had never used a hockey stick before.

The second half showed a little more fight from Guy's, but until the team can show more versatility and adaption to the changes which can take place during a game, Guy's will never be more than a second-rate team.

It would be common sense to try to defeat all the present opponents before blindly taking on better clubs. A strong fixture list is built up from performances on the field, not by an efficient Fixture Secretary or the number of drinks consumed in the bar afterwards.

Team: A. Hirst; D. Loader, K. Haynes; J. Crafts, C. Brooks, P. Rushmer; D. Steer, S. Cripps, A. Godfrey, P. Bennett, P. Liddiard.

ARTHUR HIRST

GUY'S v. SOUTHGATE II

At H.O.P. 2nd January, 1965

Result: Drew 1—1

In order to play Southgate for the first time the Hockey Club had to fit in an extra fixture out of term. The result was a good, enjoyable game and evening.

Guy's started well, and indeed throughout the game they built up many promising movements and played some good hockey.

The Southgate goal had some lucky escapes: one following a particularly fine movement which split the defence, and another when a grand first-time shot from Bennett was inches wide. However, against the run of the play, Southgate scored first with their only shot in the first half. Guy's soon replied with a fast shot from a short corner, well hit by Loader.

The second half followed a similar pattern, with Lewis, standing in at inside right, showing boundless energy and enthusiasm in harassing the opposing defence. Further goals were narrowly missed, and a particularly good shot from Din just failed to convert a good movement from Carruthers. Southgate were given little chance by Guy's defence, who could still clear more intelligently when under pressure, and Hirst had little to do.

This was a good performance, but once again Guy's proved that near misses do not score goals; and the forward line are perhaps too polite in the circle. The Club looks forward to continuing this most enjoyable additional fixture.

Team: A. Hirst; D. Loader, K. Haynes (capt.); J. Crafts, C. Brooks, P. Rushmer; R. Carruthers, M. Lewis, S. Din, P. Bennett, P. Liddiard.

KEITH HAYNES

WOMEN'S HOCKEY

The Women's Hockey Team has played six matches during the past term, a distinct improvement on last year, although the results leave much to be desired. However, while the present enthusiasm is maintained and with continued practice perhaps this situation will be rectified!

Results:—
Sat., Oct. 17th—v. King's College 2nd.
Lost 0—1.
Sat., Nov. 7th—v. St. Bartholomew's Hospital.
Lost 1—5.
Wed., Dec. 2nd—v. Goldsmith's College.
Lost 1—2. At H.O.P.
Sat., Dec. 5th—v. King's College, Hospital.
Won 4—2.

University Tournament, 1st Round.
Sat., Nov. 21st—v. St. Mary's Hospital.
Lost 0—13. At H.O.P.

United Hospitals Cup, 1st Round.
Sat., Nov. 28th—v. Royal Free Hospital.
Lost 0—4.

At the A.G.M. on December 8th, 1964, the following were elected as officers:—
Captain—Miss L. Sayles.
Secretary—Miss L. Barnett.

MARY FORTNAM

WATER POLO

University of London K.O. Championship

Unfortunately the first team had to scratch from the championship due to a late withdrawal of a member. The second team, all beginners at the game, turned up and caused an upset in the championship.

In the first round the team played The London I. Guy's were given a two goal start, and in an exciting match held The London to a draw. In the two quarters of extra time both teams scored once and the result had to be decided on six penalties—Guy's scored with three penalties and The London two, thanks to excellent saves from Wood in the Guy's goal.

In the second round, the team again had an exciting game and held Battersea II to a draw in normal time. In extra time Battersea scored twice and so went through to the next round.

Guy's team:
J. Wood (goal), D. Fould, A. Froom, M. Ham, D. Lyscombe, P. Ashford, S. Challacombe.

CROSS COUNTRY CLUB

UNIVERSITY CHAMPIONSHIPS

Parliament Hill Fields. 12th December, 1965

Guy's did very well to finish 6th college (8th last year), being 2nd hospital and small college; St. Bartholomew's coming 5th. Seventeen teams entered and a field of about 100 started.

Positions

25	P. Whitting	61	D. Choat
36	J. Wheeler	64	A. Lakin
41	J. Coole	66	E. Bowen-Jones

Guy's lies 10th out of 13 in the 1st Division of the London Colleges' League.

More people, especially freshers are needed to raise a second team for the Inter-Hospital Championships on 6th February. All standards welcome, please contact Secretary.

E. J. BOWEN-JONES

BOXING

Although the very nature of the sport limits matches, a number of interesting competitions have been embarked upon this season. The continued success of such a Club in a hospital almost represents an anachronism. Enthusiasm rarely lags, thanks largely to the assistance of trainer Charlie Pocknell, whose aid in invaluable to those who aspire to glean the finer points.

Last term commenced with a match against Sandhurst, which was narrowly lost. In November, many clubs participated in a show in the Pavy Gymnasium. Guy's boxers predominated and were not less conspicuous in skill, the standard of which was elevated by an exhibition from Bill Robinson, Olympic representative and England star. At the close of term, a match against Trinity College, Dublin, resulted in a hospital victory.

Forthcoming fixtures include matches against: Oxford University, on February 2nd in the Pavy Gymnasium; The Lynn Club novices, at Manor Place on February 15th (a new trophy will be contested and will bear the name of Matt Wells, ex British champion and Guy's trainer); London University, for the Doris Penney trophy, to be held, probably, in the Pavy Gymnasium.

Lack of support makes it seem likely that the Hospitals' Championships will once again not be held.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

THE ROYAL MARSDEN HOSPITAL, SURREY BRANCH, DOWNS ROAD, SUTTON, SURREY

Applications are invited for the post of **Resident House Officer (Radiotherapy) with Surgical Duties.** Senior House Officer Grade. This is a Post-graduate Teaching Hospital—a Radiotherapy Centre, with high energy apparatus and 100 beds. The appointment will be for one year. Application forms can be obtained from the Adminstrator, to whom they should be returned by the **5th February, 1965.**

GUY'S HOSPITAL DENTAL SCHOOL, LONDON, S.E.1.

Applications are invited for the appointment of **Full-Time Lecturer in the Dental Dept. for Children,** with duties to commence 1st March, 1965, or as soon thereafter as possible. The duties will primarily involve children's dentistry but a knowledge of orthodontics is highly desirable. Salary scale: £1,580 x £110 to £1,690 x £115 to £2,150 x £110 to £2,480 x £55 to £2,535, with superannuation. Forms of application are obtainable from, and should be lodged with the Dean, Guy's Hospital Dental School, London S.E.1, not late than **Friday, 5th February, 1965.**

PASS LISTS

ROYAL COLLEGE OF SURGEONS OF EDINBURGH

Fellowship

A. A. Akiwumi — C. E. A. Holden

ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

Diploma in Obstetrics

G. C. Barrett — J. R. Mansfield
S. E. Brook — J. J. Meanley
A. S. G. Clark — D. K. Payler
D. G. Daniel — D. A. Rees
R. A. Durance — Mary A. Rossiter
W. R. Esson — M. A. Shields
J. D. Eustace — M. V. Smith
D. D. French — T. S. Spencer
R. B. Jones — T. C. Taylor
P. M. Leney — R. J. Young

SOCIETY OF APOTHECARIES OF LONDON

Final Examination

Surgery
P. R. G. Needham*

Pathology and Bacteriology
P. B. Robinson

UNIVERSITY OF LONDON

Special First Examination for Medical Degrees Exemption

K. R. Band — R. G. Pinkham
A. P. Bennett — J. R. Stoneham
I. J. Morgan

Second Examination in Dental Surgery

December, 1964

R. J. Beacham — M. F. Richmond
M. G. H. Bishop — J. G. Ritchie
N. G. Daws — D. J. Sherwood
T. G. Dowsing — D. M. Stevens
A. E. Godfrey — A. P. Taylor
J. Hargraves — N. J. Taylor
R. S. G. Jones — N. A. P. Thompson
P. R. M. Oaten — M. R. Townsend
M. G. Pearce — R. D. Webb
S. J. Poole — Elizabeth H. Wilson
A. A. D. Reed — R. M. Wilson

Third Examination in Dental Surgery

November, 1964

Honours

P. R. Dodd (Distinguished in Dental Surgery).
Susan M. Franklin (Distinguished in Pathology and Bacteriology and Pharmacology).
V. P. Holt (Distinguished in Pharmacology).
N. J. Knott (Distinguished in Dental Surgery).
P. Longhurst (Distinguished in Orthodontics).
Marion K. Prest (Distinguished in Pharmacology).
Sarah V. Tate (Distinguished in Medicine).
A. M. Worth (Distinguished in Dental Surgery).

Pass

G. G. Ashby — M. S. Jones
Gillian Brent — P. Laver
A. H. Brook — P. G. McAndrew
C. C. Brown — I. McCormick
R. G. D. M. Burr — J. Mackey
Helen C. Carr — W. Martyn
D. E. Cooper — R. W. T. Myall
J. F. Coventry — R. C. Paterson
W. C. B. Culver — Margaret E. Pyne
P. J. Davy — J. R. Reynolds
E. G. Deere — A. J. Smith
C. D. Hawes — J. L. Storey
V. S. Holden — R. J. A. Sudworth
C. B. Hone — P. D. Venning
Christine M. Hudson — J. H. Whitworth

Part 1

Elaine D. Black — R. J. M. Jones
R. A. Burroughes — R. W. Jones
J. J. Claydon — C. H. W. Lee
Elizabeth A. Cocks — M. C. R. McMahon
J. K. Crafts — J. A. Mander
R. A. Cramp — R. H. J. Milliner
M. H. Dods — M. W. S. Newlands
S. W. Finch — I. J. Pitman
Jacqueline E. K. Hawley — Frances M. Pratt
Penelope J. Heather — C. H. Rowlinson
H. R. Hirsh — R. A. Stares
M. G. Hodge — A. S. Usiskin
J. M. Hudson — Diana J. Wagstaff
C. W. Winning

Part 2

A. J. Allan — P. A. Mitchell
A. J. Atkins — R. F. A. Murdoch
Elizabeth S. Belcher — T. W. Negus
J. M. Crawford — Susan Parry
J. Cutler — D. S. Pepper
C. Durant — J. B. Peter
D. A. Edgar — M. J. C. Purnell
J. A. Edgar — P. A. Sims
F. N. Farnworth — C. J. Sprawson
Anne M. Gaskell — T. J. Storrs
A. Hirst — C. W. Talbot
J. V. Holland — F. M. Titley
R. A. Ireland — R. Torrance
R. D. Johnson — J. M. A. Wilton
R. E. King — Delia L. Winder
P. D. Mace — A. Winskill
K. J. McGlynn — P. J. Wren

NURSING NEWS

Entered

Sister A. L. Amsden to Matron's Office.
Sister M. E. Hutchings to Preliminary Training School.
Sister M. P. Lewis to Theatres.
Staff Nurse B. Griffiths to Diplock.
Staff Nurse J. Knill-Jones to Diplock.
Staff Nurse C. Fletcher to Addison
Staff Nurse D. Richards to Cornelius.

Left

Sister K. Kershaw from School of Nursing.
Staff Midwife J. Horner from Victoria.
Staff Midwife J. Rothery from Victoria.

PERSONAL

Miss E. E. MacManus thanks the many old Guy's friends who have sent her cards and messages of remembrance. She wishes them all a Happy New Year and every blessing in 1965.

CHANGE OF ADDRESS

Major G. B. Longhurst, L.D.S., "Orchards", The Street, Holbrook, Nr. Ipswich. Tel. Holbrook 459.

BIRTHS

EDWARDS.—On December 21st, 1964, at Bridgend General Hospital, to Lucy and Derry Edwards, a daughter, Jane, a sister for Andrew.

DEATHS

MONTGOMERY.—Raymond, M.D., age 79 years, at his home, the Long House, Hazel Grove, Hindhead, Surrey (late of Bromley, Kent) on December 23rd, 1964.

MENON.—Dr. M. N., L.R.C.P., M.R.C.S., M.R.C.P., Guy's 1926, died at his residence in Coimbatore, Madras State, on 12th December, 1964.

GUY'S HOSPITAL GAZETTE

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Editors *B. H. Hicks*
P. Bowden

Sports Correspondent *A. Procter*

Guy's Hospital, London

PASSIM

Thoughts on Education

It starts with a sixth-former. It lasts five years. It ends with a doctor. It aims to send into the world a qualified physician, surgeon, midwife, pathologist, and psychiatrist, a wise counsellor, a born diplomat, a capable administrator, a man of good sense and cast-iron integrity. "It" is medical education. The equation has found many solutions, varying tremendously in philosophy, length, organisation, and in nearly every facet of training curriculum. The formula at Guy's is in many respects highly successful, but loyalty does not blind us to its deficiencies. If education here, as elsewhere, is to improve, the directions of change, their ultimate target, and the rationale of change must be known and understood.

Medicine as a subject of study has itself become a morass of factual and hypothetical knowledge, defying serious thought and making even superficial analysis difficult. Pious platitudes about the evils of specialisation are finding little sympathy with the student, faced as he is with the massive tomes on his subjects, clinical and pre-clinical, stuffed with fresh ideas and dreary details. It is a diet which dooms him to intellectual constipation, or intellectual diarrhoea. It must be recognised that the modern practice of medicine is composed of specialists and specialised generalists, and one can only reasonably train students for the latter. This point made, it is even more important that we remember that the doctor is for his patients, not for the laboratory.

The doctor is a part of his society in a unique and privileged way. Even in the welfare state he is awarded status, he is trusted and known by many with affection. Governed to some extent by the structure of his own background, he yet exerts a powerful and irrefutable influence on his patients and his—and their—government. In modern society, this position is little affected by monetary considerations, and as the public is better educated, so ignorance will fall away as the barrier it has sometimes been in the past. Not so happy is the new attitude of rejection which makes geriatrics so often a question of disposal rather than medicine. In similar vein, many are progressively more dependent on medical and welfare services, for the lack of a little more personal effort. For all its qualities and failings, this *is* the society for which doctors are being trained, and the medicine it needs is social medicine.

The physician of to-day is functioning worthily if he is integrated not only into his hospital's image of the "good chap", but into his society and its welfare structure. His personal relationships with his patients, still vital, must be expanded, to an awareness of far more than his patient's condition, to its social context and significance. The physician must be trained for this; he must understand not only his patient but the social forces acting on him. He must understand not

only his patient's development, but the evolution of the society in which he finds himself. Unless these broader understandings are inbred, then the doctor will not play his part in the further evolution if his people and his art.

In this and the next two issues of the *Gazette* a number of contributors have set down their views on medical education. It is hoped that these articles will serve as a stimulus to and basis for open discussions in the correspondence columns of the *Gazette*. We would particularly appreciate opinions from general practitioners and students.

We note from a letter in this week's correspondence column that the Editors of *Pulse* are in difficulties as far as the attitude of students is concerned. We can offer them few words of comfort, only that their most destructive critics will be the last to contribute to their unique journal. It will anyway be of interest to see if Medical Education or *Pulse* can indeed evince a response from that amorphous "student body", which apparently is so misrepresented. Or do only stomachs stir to action?

In Passing

Life in the self-contained community of a hospital tends to accentuate those parts of social etiquette that are most foolish. Most faces in the hospital are familiar, some are even friendly and somehow our recognition must be communicated, anything goes, from a raised brow to a full-blown smile.

Some make it their duty to hail all, they either shout a cheery greeting across the grass and wave, very conspicuously, from in front of the Medical School, or veer from their path to add a friendly pat to an already intimate wink. Others have eyes which search each face, looking and longing for some hint of recognition in someone, anyone. The more unsociable cross the park, head bent earthwards, recognising no one, foreign and unknown. These are the brainy ones with more to do than pass idle "good days"—or perhaps they've merely a hangover.

The Consultant passes, grand and rich, forgetting the face that was surely unforgettable, his prodigy withers 'neath the icy authoritative stare. Certain people must be ignored as is the loving, but unloved, nurse and the creditor, but to ignore the disciple is unforgiveable.

The most ludicrous situation arises when one sees an acquaintance approaching. One waits until the person is alongside and then looks up and utters a startled "Hello!" in a high-pitched, ineffectual voice, or one looks into an empty sky while blowing one's nose. The other similarly indulges in rituals of avoidance.

Camus thought that man must be acknowledged by other men. All consciousness is, basically, the desire to be recognised and proclaimed by other consciousnesses.

The Minister of Health has appointed Lord Robens Chairman of the Board of Governors of Guy's Hospital, as from the 1st June, 1965. He will succeed Mr. Edward G. Slesinger who has been Acting Chairman and Chairman of the Board since the death of Lord Cunliffe in November, 1963.

Mr. A. E. Orchard-Lisle, F.A.I., was elected vice-chairman of Guy's Hospital at the Board meeting on November 2nd, 1964. Mr. Orchard-Lisle has been a Governor since April 1st, 1953, and has done a great deal for the Hospital, both in helping to build up the Endowment Fund, and also as Chairman of the Building Committee. Under his Chairmanship, New Guy's House was built, and Guy's House was reconstructed.

In the New Year's Honours list, two Guy's men became Knights: Professor R. V. Bradlaw, C.B.E., F.R.C.S., F.D.S., R.C.S., and Mr. H. J. Croot, C.B.E., M.B., B.S., F.R.C.S.

Professor Bradlaw trained at Guy's as a dental surgeon, and later became Professor of Dental Surgery in the University of Durham, and worked at Newcastle. He was the first Dean of the Faculty of Dental Surgery of the Royal College of Surgeons. He is at present Dean and Director of the Institute of Dental Surgery, University of London, and works at the Eastman Hospital, where he is Director of the Post-graduate Institute. He is President of the General Dental Council.

Mr. Croot qualified M.B., B.S., in 1930, and obtained the F.R.C.S., England, in 1938. He formerly worked in China, but for many years has been a surgeon in the Medical Services in Africa. He is at present Senior Specialist and Surgeon in Uganda.

To the many that have followed the death of Sir Winston Churchill, we add our tribute.

GUY'S DIARY

EXHIBITION.		*Breast Cancer.*
9th T.	1.00	Professor HUNT. Clinical Lecture. Anatomical Theatre. *Regulation of Gastric Secretion.*
11th Th.	1.00	Mr. WASS. Clinical Lecture. Anatomical Theatre. *Diverticulitis of the Colon.*
12th F.	2.15	Combined Round. SIR RUSSELL BROCK and the Depart. of Thoracic Surgery.
12th F.	1.00	Professor ACHESON, Professor of Epidemiology and Medicine, Yale University. Clinical Lecture. *The Stroke Problem.*
16th T.	1.00	Dr. MacKEITH. Clinical Lecture. *Cerebral Palsy.*
18th Th.	5.00	Mr. SCHURR. Neurosurgical Round. Clinical Theatre.
18th Th.	1.00	Mr. GLOVER. Clinical Lecture. Anatomical Theatre.
19th F.	2.15	Combined Round. Dr. TROUNCE, Dr. EVANS, Dr. MacKEITH, Dr. JOSEPH and the Depart. of Paediatrics.
19th F.	1.00	Dr. TROUNCE. Clinical Lecture. Anatomical Theatre. *The Mode of Action of Antibiotics.*

THE AIMS OF MEDICAL EDUCATION

SIR CHARLES ILLINGWORTH

REGIUS PROFESSOR OF SURGERY, UNIVERSITY OF GLASGOW

What sort of doctors are required in this second half of the twentieth century and how should the training of students and post-graduates be modelled to meet this need? Fifty years ago the answer would have been simple. Young Bill Jones, on the morrow of graduation day, must be ready to start work in a slum practice in the industrial north or a colliery club in the Rhondda, or to pack his bag and take ship to Peru or Patagonia; and in any of these places he would be required to undertake, unaided, the full range of general medicine, operative surgery, obstetrics, eyes, ear, nose and throat and every other speciality.

By contrast nowadays his immediate needs is to be a good house officer. If he has had the necessary basis of education in the medical sciences his preregistration internship and the hospital experience which follow will give him all the opportunity he needs to develop his later career.

But while our present needs are clear the future must be largely speculative, for the revolution of 1948 has not yet run its course and the conditions of medical work in this country are still not clearly defined.

A few years ago one would have said that general practice was doomed, that the rôle of the family doctor would be to give homely advice, to comfort and reassure, and that all serious medical care would be organised from the hospitals and clinics; but now a new spirit is abroad and there seems to be a possibility that with wise guidance the practitioners may regain some of the status and responsibility they enjoyed in the past.

Then take specialist practice. A decade ago it looked as though private surgical practice was doomed. As hospital facilities were improved, surely no intelligent Englishman, still less a Scot, would pay for private care. Indeed the proposition may still be true, if by hospital facilities we mean amenities as well as medical skill. But who in those days could foretell that the break-up of the British Empire would increase the medical traffic between its former capital and the ex-dominions, that every merchant from Afghanistan to Zanzibar who could afford the price would bring his hernia to London and that Harley Street, like a new Venice, would hold the gorgeous East in fee.

From the point of view of the schoolboy about to embark on the medical course, this element of adventure and the diversity of careers which develop provide the real attractiveness of medicine as a profession. Most boys and girls at sixteen or seventeen years of age have still to discover their aptitudes and ambitions. It is an advantage to be able to postpone for five or six years the decision between general practice and a laboratory job, between consultant work and administration. It follows from this that the early years of the curriculum must provide a basic medical education to build the proper foundation, but the later years could well be modified to prepare for different pursuits.

Moreover, we must take into account the needs of students who may later decide to emigrate. The brain drain is no new thing in medical experience and it will assuredly not cease if our young men continue to have the divine discontent of every progressive race. Moreover the brain drain is not altogether a bad thing. Scotland with its four large medical schools and an output of graduates far beyond the needs of its own small population has been exporting doctors in large numbers ever since the medical act of 1858 gave them the right to practise throughout the Queen's dominions. At first the floodtide descended on England, and at one time half the practitioners in the industrial north were Scots. Then it spread to Canada, where most Professors at the present day are MacKenzies or Fergusons or McLauchlans. The same process is evident in the Antipodes and other parts of the English-speaking world. These emigrants enhance our own reputation in the world at large and perhaps even give benefit to the countries at the receiving end. Provided they go without a chip on their shoulder they can be the best of ambassadors.

As for the present curriculum I am pretty sure there will be unanimous agreement on the following propositions.

(1) It is too long. Admittedly the training of a doctor must be a lengthy business, but training can go hand in hand with responsibility. A student with only the menace of an examination to spur him on will naturally do the minimum necessary to gain a pass. An intern, with personal responsibility for patients, will work himself to the bone, and if he is properly guided and not exploited he will benefit in the process. We should adapt the undergraduate curriculum and the preregistration training to meet these simple truths.

(2) It is out of date. Admittedly to learn the course and relationships of the greater superficial petrosal nerve is a valuable exercise in memorisation as well as a constant reminder of the usefulness of pelmanism; but equal practical value and a larger intellectual satisfaction could be gained by memorising the Chinese alphabet. Admittedly also the technical details of the fifty-two varieties of herniotomy have an interest for the would-be herniotomist but can hardly be regarded as essential elements in the training for a liberal profession.

(3) The educational methods are obsolete. On Clydeside to teach shipbuilding apprentices how boats are built we do not give them an old hulk to tear to bits. We give them blueprints and working models

and up-to-date visual aids. Yet to teach the structure of the body we still anatomise a corpse. Our methods of clinical instruction are equally obsolete and inefficient, these tedious ward rounds, itinerant reiteration of the obvious to the tune of aching feet and wandering thought; those amnesic periods of self-hypnosis in the penumbra of the operation theatre.

(4) Clinical science is just as basic as preclinical sciences. In the days when all physicians were empiricists and all surgeons merely dexterous technicians the basic sciences comprised only the laboratory disciplines of anatomy, physiology and pathology, but these days are past and much of the basic science of medicine nowadays can best be taught in the clinical professorial units and their associated departments.

As to the future, prophets are doomed to discomfiture but at least it seems certain that the sum total of medical knowledge will continue to increase, so if omniscience is demanded of our students we shall need to make further inordinate increases in the length of our curriculum. But since it seems equally certain that specialisation also will continue to increase, there will no longer be any need to be omniscient. The public has accepted this situation these many years; it is time our teachers realised it too. We must provide the foundation and scaffolding of a good education but not every brick.

Looking at the period of medical training as a whole it is clear that it must consist of two phases. First there is the phase of basic scientific training, which should include modernised versions of the laboratory discipline plus some training in clinical science and the general principles of medicine and surgery; and secondly there is the phase of practical experience or apprenticeship. In the circumstance of half a century ago the undergraduate curriculum necessarily included the whole of both phases, but in the context of the present day this no longer obtains. The scientific education of phase one is an academic training suitable to the student life; the practical apprenticeship of phase two should be relegated to the preregistration period.

I believe that a medical course on these lines could be encompassed without increasing the total length of training. The undergraduate period, modified as I have suggested, could be shortened by at least a year. A preregistration period lengthened, by a similar amount, could be remodelled in the sense of making it a phase of further education with three monthly rotation appointments in a variety of departments and would provide an apprenticeship suitable to whatever future career the young graduate had in mind.

Guy's Hospital Theatre Club

ONE WAY PENDULUM, by N. F. Simpson, will be presented in the Physiology Theatre from Monday, 1st March, until Friday, 5th March. Tickets will be available outside Smith's or from the Secretary from Monday, 15th February. This outrageous comedy, now filmed, will appeal to all our regular audiences and, we hope, many more.

PETER DAVENPORT (Secretary).

Medicine outside the Hospital

G. O. BARBER

GENERAL PRACTITIONER, DUNMOW, ESSEX

Illness is not just something that happens out of the blue: long before a patient becomes aware that all is not well with his body or mind, the seeds of that illness have been sown; the stresses of his environment have been at work on some hereditary or acquired weakness, and have slowly led up to the breakdown which has brought him to the doctor. Even with accidents careful research has revealed a "proneness", subject to the same factors of heredity and environmental stress.

A medical student sees none of this. The cases in out-patients or in the wards are in the stage where illness is established; all the prodromal stages have occurred outside the hospital in general practice. It is only there that one can see the natural history of disease at work.

This applies equally after discharge from the hospital back into the environment, and subject to the original stresses which led up to the illness in the first place. Here lies the great challenge to the family doctor, to break the vicious circle, to help the patient to overcome the disability, and to stay well and at work in spite of the particular stresses which threaten the particular weak spot in that patient.

It is illogical to try to equip the young doctor with an education which is focused entirely on this "hospital incident", and not to give him an opportunity of seeing the whole process from start to finish. In addition, it omits any experience of the vastly larger amount of illness which runs its whole course entirely outside the hospital. The decision as to which cases will be referred to hospital lies entirely with the general practitioner, and this depends on the scope of his facilities for diagnosis and treatment.

In recent years both these have increased, and teachers have told me that it becomes harder each year to show students straightforward cases of many types of illness which in my student days were usually referred to hospital: for example, lobar pneumonia, an acute middle ear with a bulging drum, or a case of scarlet fever. Yet every day in practice we are seeing the early stages, which would develop into just those conditions without our very effective modern drugs. Even when fully developed, they can often be treated safely at home. But it is just because treatment has become so effective that the medical student has no chance of developing those skills in hospital, and has

to depend on general principles when he is first confronted with them in practice.

Some teachers of medicine have long been aware of this defect in the medical curriculum, and in the *Recommendations of the General Medical Council* of 1957, it was stated: "It is desirable that the student should be given opportunities to learn something of the work of the general practitioner."

Individual medical schools have experimented in various ways: for instance by lectures, which after all are only accounts of experience secondhand: by half-days or whole weeks with the G.P.: and by watching a General Practice Unit attached to University—which is bound to be rather artificial and can even become a sort of glorified out-patient department. One consultant has a regular G.P. on his rounds to comment on his side of the case. All these schemes are good, and recently the tide has shown signs of turning: a leading article in the *Lancet* of 15th February discusses the growing interest in medical schools all over the world about the introduction of the student "to the medical problems which arise in patients outside hospital". This is just what Sir Robert Platt has said recently: "It is in general practice that the student can obtain his widest experience of disease, disease which he will never see in hospital, in its early and its late stages, and with all its social implications." The student who goes as far as qualification without looking outside the hospital has only seen half of the picture, and he is like a biologist who has only worked on animals in a zoo, and has never seen and studied them wild in their natural surroundings.

A student can have no idea what an exciting and rewarding branch of medicine lies in general practice until he has seen it at first-hand. He must beware of forming any opinion until he has taken an opportunity of seeing it for himself, and nowadays this is so much easier than it was.

Ten years ago a number of ordinary general practitioners decided to form a College, with three main objects: undergraduate education, post-graduation, and research. And the undergraduate side was organised to cover every medical school in the country, so that any student could, if he wished, spend a week, or two if he liked, with a family doctor in any part of the country he liked. Details of this scheme can be obtained from the Office of the Medical School, or direct from the Secretary, College of General Practitioners, 14, Princes Gate, London, S.W.7.

The Scope and Quality of General Practice

Two women lie side by side in the gynaecological ward. One has an inoperable carcinoma of the cervix, the other is in for a D. and C. and biopsy. Why the difference?

And everywhere else in the hospital, in out-patients, and in the surgical and medical wards, there is the same problem—advanced and early cases side by side. Why does one general practitioner send them up early and another too late? Of course, the answer is simple: one woman went to her doctor as soon as she noticed anything wrong,

and he took no risks with her future health or even life. In the other case, either the patient or the doctor left it too late. It is just one of the differences between good and bad general practice. Because we must make no mistake, and admit that there is a great variation in the quality of the medicine that goes on in general practice.

Dr. Collings made a survey in the *Lancet* in 1950, and painted a gloomy picture: the British Medical Association Committee made another survey in 1953, and gave a picture of the average general practice throughout the country, and finally Dr. Stephen Taylor (now Lord Taylor) made another survey for the Nuffield Provincial Hospital Trust in 1954, when he concentrated on only what could be found in *good* general practices, and he published these results in a fascinating book entitled "Good General Practice". I advise every student to open a copy, because once he has done so he is unlikely to put it down unread.

General Practice and the Future Consultant

Some medical students can decide quite early that their future is going to lie entirely inside the hospital, they have the ability to become future consultants, and it is amongst them that will be found the teachers of future medical students. Why should they be concerned with what goes on outside the hospital?

It is in fact even more important to them than to future general practitioners that they should have an awareness of the medicine outside the hospitals. As young consultants they must have a first-hand idea of just these conditions of heredity and environment and stress which brings the patient to them: and it is as future teachers that they must be able to view the whole patient in relation to his background, so that there is no risk of their teaching being purely academic. The whole object of this principle of showing the student something of work outside the hospital is to give a more complete picture of medicine and the processes that go on in the human animal, and it is most definitely *not* to teach the organisation and the methods of general practice to those students who are going to be the G.P.'s of the future.

Common Diseases

Figure 1 gives a series of illnesses in general practice which were collected from 1,000 consecutive cases some years ago. It is very interesting to compare this list with the questions which the medical student meets in the examination hall, and on which depend his chances of qualification. The special departments of psychiatry, skins, eyes and ears and fevers form quite a large proportion: but it is, of course, impossible to include a question on each of these every time in the examination.

I know that in my days we used to make an extensive study of the previous examination papers, and decide from that which special departments we should attend and which we could afford to skimp: it was an admirable device for trying to get through the examination with the minimum amount of work, but as a preparation for the genuine work of general practice it was liable to leave very large

Figure 1.

ILLNESS IN GENERAL PRACTICE IN RURAL SOUTH-EAST ENGLAND 1,000 CONSECUTIVE CASES

ILLNESS GROUPS	
Respiratory disorders	195
Unclassified—largely psychological (Anxiety and maladjustment)	131
Alimentary disorders	113
Circulatory disorders	105
Skin disorders	75
Prophylatic injections Diphtheria, whooping cough, Tetanus, T.A.B., Hayfever, etc.	75
Pregnancy and confinements	51
Gynaecological conditions	28
Accidents	32
Infectious disease	32
Genito-urinary	33
Eye conditions	29
Ear conditions	28
Tests for Rhesus factor and blood group	22
Psychiatric disorders	21
Endocrine disorders	19
Examinations for Factory Act, Friendly Societies, Insurance	11

gaps in our experience, which would most certainly be found out in the course of our first weeks on the real job! General practice is rather like going to sea, it always calls your bluff.

The Student Attachment Scheme

At present, medical schools vary widely in the opportunities which they offer to their students to see general practice at first-hand. In one or two it is a compulsory part of the curriculum. In the majority it is voluntary, but there is great variation in the way it is viewed. In some hospitals it is made easy for the student because the office of the medical school keeps in touch with general practitioners in many parts of the country, and sends students to them regularly: the medical school is responsible for the expense which is involved, the journey, and any board and lodging which has to be paid (because not all doctors' wives will put up with a continuous series of young men occupying their spare rooms!) In some schools the time spent with the general practitioner is included in their clinical period, and does not have to come out of the precious holidays which most students regard as sacred to more important things like travel, sailing and winter sports.

The proportion of students who make use of this opportunity seems to vary very directly with these conditions. General practitioners who are keen on the maintenance of a high standard of general practice, and this of course depends on the attitude of the teachers in the medical schools, hope very much that conditions of this kind will soon prevail in all medical schools as a routine.

If a glimpse of general practice benefits a student, it also gives the doctor a healthy contact with the younger mind. If you have a young man or woman at your elbow for a week it is quite surprising how it makes you realise your shortcomings. Laziness of thought, "what do I really mean when I say this to the patient? Why don't I take a swab—send a sample—have the blood done—or an X-ray? Have I mislabelled this case many years ago and never re-assessed my diagnosis and so missed an obvious development? And above all, does this young man know a lot more about the modern work on this case than I do? Then is my technique really thorough? Is this syringe or suture really sterile? Is he noticing that I have not taken my coat off, rolled up my sleeves and scrubbed-up properly?"

A student in his final year probably is near the top of his curve of academic knowledge, and if the trainer is willing to accept it he can have a week of first-class post-graduate instruction from his pupil! At the very best he can get some satisfactory assurance that he is not all that out of date.

A yardstick for the future

Finally, a glimpse of general practice is essential to the future young G.P. for a different reason. The student is not going to learn the whole of general practice in just one week, that can come later as a trainee assistant or an assistant with a view to partnership in a practice later on (there is a scheme in the Wessex Region by which a newly-qualified doctor takes a rotating series of house appointments for two years, and part of that time is spent as a trainee assistant in a good general practice). But what the week will show to the young student at an impressionable age is a certain *standard* of practice, so that later on he has a yardstick against which he can judge other practices which he will see. Either they are better than the one that he saw originally, or if they are not so good then he can tell himself he has seen something better, and he can therefore improve on it as time goes on.

There is at present a good deal of change going on in practice, for the better. We trust much of this will depend on us who are at present engaged in general practice outside the hospital, but in the long run the standard of general practice will depend on students of to-day, who will become the general practitioners of to-morrow. It is our duty to do all we can to show them how far we have got, and it is then up to them to see that they can do better.

Dental Students' Congress

It is announced that the British Dental Students' Association and the International Association of Dental Students, will be holding a combined Congress this year.

The Congress will be held at Guy's between August 13th and 22nd, and will consist of a series of academic lectures, together with social occasions, including a visit to Oxford and Stratford.

Further details will be announced later.

A Personal View

DENNIS BAINBRIDGE

After Robbins a revolution, in which the number of places in higher education are to be expanded two-fold in twenty years. "An English Revolution". His report, similar to one by the Taylor committee in 1961, was written and widely accepted because of one main overshadowing threat, that Britain was inevitably going to fall behind in its economic expansion due to a future lack of scientific and technological graduates. To date, the main controversy has been over the number of Ministers of Education that are to head the projected system, and the main doubts have been over the quality of graduates to be produced under these new conditions. Medical education will inevitably be concerned in this expansion, but the ability of our present institutions to cope in the future is not self-evident. If more and better doctors are to appear in the next twenty years, the missed opportunities and deficiencies of to-day's teaching methods will have to be corrected, and attempts made to provide adequate hospital facilities for future numbers. Although, personally, I would like to see the whole system of medical education radically altered, I can be realistic and recognise that any changes will have to be made within the existing structure.

Towards What ? . . .

The changes I would like to make would be directed to produce that controversial figure, "a good doctor", controversial in that the meaning of good is not definable absolutely. *My* practical definition is that he should be able to examine, diagnose, and manage physical and mental illness; that he should be aware of the social dislocation caused by the illness and know how to ameliorate it; and that in his social position be capable of effective concern in social reform by example and education. In essence, my aim is that every medical graduate could become a General Practitioner, and that he can also exist as an educated person able to be a power in improving the public service in which he works.

The type of education that is provided beyond "O" level in this country is in general purely vocational, with a blithe disregard for extending education to cover an awareness of the implications of living in a highly developed society. Meaning that the attitudes which we inherit are rarely challenged by being exposed to the rigours of facts and logical thought, so that they remain undeveloped and inappropriate in the different environment in which a student finds himself after graduation. It is to alter this inadequate situation that I think it is worthwhile introducing such general subjects as Anthropology, Philosophy and Psychology into higher education and our

pre-clinical studies in particular, to demonstrate the principles behind individual and social behaviour. To judge the number of hours devoted to these subjects and even their immediate usefulness is difficult, and its introduction will be questioned, but if it does no harm except taking up time it could displace irrelevant pre-clinical teaching or be attended voluntarily with few repercussions.

As far as the expansion of the pre-clinical course is concerned, three years would bring it more in line with a B.Sc. university course, allowing the extra subjects to be included, and I would hope that eventually the pre-clinical period would be transferred from the many medical schools to a few university colleges. This seems to have two advantages, firstly, that teaching would be more efficient and better, by reducing the number of departments and increasing each in size, and secondly, that the cloistered atmosphere of the medical school would be vitalized by having students in other faculties at the same colleges. Incidentally, this would make it easier for medical students to do Ph.D. courses, and easier for re-entering academic medicine after completing the clinical course. A number of subjects at present taught at the hospital could be usefully put into context with the social science and pathology course, including Public Health, Epidemiology and Legal Medicine.

To An Overall Comprehension . . .

By this time the student would have been introduced to the background of medicine as a study of disease and as a social science, from a theoretical standpoint. He now comes into the hospital for three years, and in this period will expect to learn the specifics of disease related to the individual, and eventually relating the patient to his environment. Expect he may, but in fact the management of a patient is mainly concerned with tablets and physical treatment and the social factors both as causative and as problems for the ill patient are largely ignored. I make the suggestion at this stage to introduce an American idea, that long-term follow-up of a few patients in the paediatric, medical or psychiatric fields can be an effective way of putting the student into contact with a patient's home life and the auxiliary services which can help a patient during a chronic stage of an illness or convalescence.

And a Bedside Capability . . .

Even the basic teaching of history taking, examination and diagnosis and treatment is not faultless, probably because it is so unaided and is conducted in such uncomfortable conditions. If there are widely differing standards of lecturing it seems a folly to expect that all teachers can give their best with only a blackboard, chalk and a slide projector. Combined with the fact that the two main lecture theatres in Guy's are a positive deterrent to good lecturing and attentive audiences.

The principles of learning are not unanimously agreed upon, but in general a student requires frequent exposure of all his senses to a problem which is to be incorporated into his future behaviour, reinforced by suitable emotional stimuli such as satisfaction on his part

and praise from his mentor. This brings me to criticise the most important part of our present teaching, the ward round. At present, its emphasis seems to be on quizzing the student on their findings regarding several patients in the ward. As an instrument of teaching this seems to me to have its values reversed, and often there is only one qualified person expressing an opinion on each case, because no other personnel are present or invited, and a free exchange of ideas and views cannot take place when the whole affair is conducted as a viva voce. This is an inheritance that this and other hospitals have had visited upon them, so much so that even "combined" rounds are often sectarian, especially as far as physicians and surgeons are concerned. Naturally, the system reproduces itself accurately, and is thereby caught in its own web, a system aggravated at present by any effective channel of communication between students and staff, either for voicing grievances or planning changes in the future. A further innovation I would like to see is a tutorial system as an adjunct to the formal clinical teaching. This could have the effect of involving the student more closely with the medical profession by the effect of a personal relationship between tutor and pupil, though this would depend to a large extent on the personalities involved.

In general I have outlined the direction in which I would like to see medical education changing, and suggested some improvements in the present teaching arrangements, and postulated the change of attitude toward undergraduate teaching that I think is necessary for these changes to have their greatest effect. However, only by analysing the effects of introducing such changes and questioning their value will the investment of money, time and talent be better applied to-morrow than it is to-day.

NOTICES

Guy's Hospital Residents' May Ball

The Ball will be held at the " Pigalle", Piccadilly, on Friday, 21st May, 1965. It is hoped that the night-club atmosphere will make a pleasant change from the usual hospital balls. Dancing from 8 p.m. until 3 a.m. will be to the restaurant's two resident orchestras, and guests will be able to take dinner at any time they wish from 8 p.m. until midnight, when the "Pigalle's" famous sixty-minute floor show and cabaret will be presented. Double tickets will cost 4½ guineas and will be available from the President of the Residents or myself. The Ball is organised for all members of the Hospital community, past and present, students and nurses, and all connected with the Hospital are particularly welcome.

D. K. C. Cooper, *Chairman, Ball Committee.*

South Wales Guy's Hospital Society

The 13th Annual Dinner of the Society is to be held on Saturday, 13th March, in the Park Hotel, Cardiff. (This is the occasion of the Rugby International at Cardiff Arms Park.) The President for the evening will be Mr. G. Morwent Brown, L.D.S., R.C.S., one of the founder members of the Society, the other, Dr. R. Baker, having been Secretary to the Society since it was founded. All Guy's men in South Wales will be welcome.

H. R. S. Harley

15, Augusta Road,
Penarth, Glam.

CORRESPONDENCE

"Pulse"

SIR, We would like to bring to the notice of medical and dental students the present pitiful position of "Pulse", Guy's students' magazine. At the moment the magazine is on the verge of sliding into oblivion, like many other worthwhile student ventures that have met this fate in the last few years.

With the opening of the East Wing, Guy's must surely have the best student facilities in the University. It would be deplorable if this event signalled the onset of a decline in student activities here.

"Pulse" is the organ of student communication, ideas and criticism, and as such it is a direct reflection of student life at Guy's. The present editors still require, and would welcome, articles, letters and ideas for the next edition, which should have gone to press last term. We would also like to remind secretaries of societies and clubs that "Pulse" can be used as a medium for publicity.

Yours, etc.,

TONY RAYNES,
STEPHEN ROBINS,
Editors of "Pulse."

Guy's Hospital, S.E.1.

The Cold Baby

SIR,—Some of your readers, particularly those from overseas countries, will be interested and perhaps surprised to learn that the condition of neonatal hypothermia, so ably reviewed in the last issue of the *Gazette* by Dr. Trevor Mann, occurs also in tropical countries. In Uganda, for example, where the climate is incomparably pleasing to visitors from temperate zones, the temperature often falls at night time to 60-65° F. By rural African standards, garments familiar to us are very expensive and inadequately clothed newborn babies may easily become chilled through exposure.

Yours, etc.,

R. H. R. WHITE.

Department of Paediatrics,
Guy's Hospital, S.E.1.

Sister Falwasser

SIR,—The news of the pending retirement of Sister A. Falwasser, Sister Job, at the end of February, will be received with profound regret by a vast number of Guy's nurses, doctors, and the widest circle of friends both at home and overseas.

Sister Job came to Guy's in April, 1925, and was appointed Sister in 1931. She will, therefore, have completed virtually forty years of service within the Hospital. There can be very few whose record of total devotion, example, teaching and humility can bear comparison: there can be none who can surpass it.

I have obtained a leather-bound book in which those who would wish to be connected with a farewell gesture to Sister Falwasser may sign their names, and leave a donation in the Matron's office. I will divide the book into three sections:—

Nursing Staff, Past and Present.
Medical Staff, Past and Present.
All other Friends.

In order that those who are abroad may not feel dissociated from this arrangement, I will welcome their signatures on suitable pieces of paper which will be affixed into the book accordingly. Receipts will, of course, be despatched without delay.

This opportunity will remain available until after the reunion of the Guy's Hospital Nurses' League on May 12th next.

ANNE M. JOHNSON, *Matron.*

Guy's Hospital,
London, S.E.1.

Guy's Hospital Students' Club

The attention of members of the Students' Club is drawn to the notices which have already been posted in the Hospital about the election of the student representatives to serve on the Council of the Students' Club for the year April, 1965-66. The arrangements for the election of these representatives will be as follows:—

1. The closing date for the nomination of candidates is THURSDAY, 18TH FEBRUARY, 1965. The method of making nominations is explained in a notice on the board in the Entrance Hall of the Medical School.
2. The election will be held on THURSDAY, 4TH MARCH, 1965.
3. A Ballot Paper will be sent to every medical and dental student before the date of the election, giving the names of the students who have been nominated to represent their years or groups.
4. Each student should complete his/her Ballot Paper and place it in a Ballot Box on the day of the election between the hours of 9.00 a.m. and 5.00 p.m. Ballot Boxes will be available in the Entrance Hall of the Medical School, the Entrance Hall of the Dental School, outside Smith's bookstall, in the lobby of the East Wing of Guy's House.
5. Members may vote only for the election of the representative or representatives of their own year or group, with the exception that students resident in a Guy's Hostel may, in addition, vote for the Hostel representative.
6. By the Rules of the Students' Club, NO REPRESENTATIVES MAY BE ELECTED UNLESS AT LEAST ONE-THIRD OF THE GROUP TO BE REPRESENTED HAVE VOTED.

It is hoped that members will ensure that candidates are nominated for the vacancies for the representatives from the various years or groups before Thursday, 18th February, 1965, and that all students will vote for the candidates of their choice on the Election Day.

ANNUAL GENERAL MEETING

Notice is hereby given that the Annual General Meeting of the Students' Club will be held in the Quiet Games Room in the Students' Club in the East Wing of Guy's House on TUESDAY, 9TH MARCH, 1965.

AGENDA.

1. To confirm and sign the Minutes of the last Annual General Meeting.
2. Matters arising from the Minutes.
3. To elect the following Officers for the year 1965-66:
   (a) a President of the Students' Club;
   (b) a Senior Secretary;
   (c) a Senior Treasurer;
   (d) a Student President from among the student representatives on the Council;
   (e) a Student Secretary from among the student representatives on the Council;
   (f) a Student Treasurer from among the student representatives on the Council;
4. To receive the Accounts of the Students' Club and of the Bar for the year 1963-64.
5. Any other business.

G. M. DAVIES
(Hon. Secretary, Guy's Hospital Students' Club.)

SPORT

RUGBY FOOTBALL

Guy's have had mixed success in the three matches preceding the Hospitals Cup competition. In the first, against Taunton, away, Guy's made one mistake in the opening minutes of the game; the opposition scored, and there was no further score in the game. The ground was very wet, and the game of necessity was dominated by kicking and forward play.

The fixture against Devonport Services was unfortunately cancelled due to waterlogging of their ground. However, a game was arranged against Reading, and it turned out to be a very entertaining encounter. Guy's were in very good form against a team which has beaten St. Thomas's and narrowly lost to Bart's, and attacking rugby produced 6 tries, the final score being 22—6.

Against Old Whitgiftians, Guy's had the usual tough game. The captain, due to an exacerbation of the pox he and other members of the scrum had suffered from earlier in the season, thought it prudent not to play. Guy's played down the hill and with the wind in the first half, but did not exploit these conditions sufficiently and in fact were 5—3 down at half-time. It was disconcerting to see so many passes dropped. In the second half, however, Guy's played much better rugby and won a lot of the ball from the tight, but they were unable to score again and finally lost 11—3.

Hospitals' Cup Match: *Guy's v. Charing Cross*: *Won* 14—3. *A full report will appear in the next issue.*

ASSOCIATION FOOTBALL

Four games have been played in the last fortnight. Guy's beat U.C.H. 7—1 in the quarter-final of the Hospitals Cup and thus enter the semi-final. In this game, C. Wright, an ex-member of the 1st XV, but now playing football because of a shoulder injury, scored a hat trick. Guy's also won through to the semi-final of the University of London Cup, by beating Queen Elizabeth College 2—0, in a very hard fought game, Cutler scoring both goals.

In a Hospitals League match against Bart's, Guy's won 3—0, Cutler again scoring all the goals. At the moment, Guy's head the league with 13 points from 7 games, level with Thomas's, but Guy's have a considerably better goal average.

Last Saturday, Guy's lost 5—2 to Old Malvernians. This was not a very successful game for the team, and more than one goal was scored for the opposition by a Guy's man.

HOCKEY

It may be of interest to club members and others to know of a number of fixture alterations being made for next year. As a result of last season's success, the club has had the opportunity to arrange block fixtures with several leading club's 2nd to 5th teams. Because the club is able to run four teams regularly, and next season should be able to use the Peek Frean ground as a permanent second home pitch, it is in a position to accept these fixtures. This has necessitated dropping a few old fixtures, which is not easy in a well balanced fixture list; however, the Committee considered that as well as weaker fixtures, those clubs unable to offer good facilities should be omitted. For a number of years the 3rd and 4th teams have played away nearly every week and have put up with, in some cases, very poor conditions; and it is felt it is now unnecessary to ask them to continue doing so.

The club is fortunate in being the only hospital able to run four teams and so embark upon this type of fixture. It is hoped that the present success of the club will continue and that four good teams will be able to enjoy a strong fixture list for many years. Strong support in the 3rd and 4th teams has put the club in this position, and should maintain the club's reputation in the following years both on and off the pitch. The club's strength lies in these teams.

RUGBY FOOTBALL

GUY'S v. READING

Away — Saturday, 23rd January, 1965

Result: won 22—6

"Guy's have been very fast and have attacked continuously all afternoon—very entertaining." This, and similar comments, were overheard as your correspondent glided unnoticed amongst the Reading supporters, armed with his blue and gold flag, notepaper and pencil last Saturday. The fixture, the Hospital's first with Reading, had been hurriedly arranged with the London Bureau on the previous evening on learning that the Devonport Services ground was under water.

An appropriate degree of respect having been forged, the Hospital proceeded to give a delightful and commanding display of continuous, fast, open, attacking rugby. Reading, lacking some of Guy's skill, fitness, and speed, countered with considerable determination and showed equal willingness to run with their smaller share of the ball. The spectators were thus treated, on an afternoon of near perfect conditions, to a superb open game fought in fine spirit and producing no less than seven first-class tries.

Guy's first constructive assault was initiated in their own twenty-five, when Rowland and Edgar put Kerner away on one of his characteristic powerful bursts down the wing. With only the full-back to beat he found the ubiquitous Baker ready to receive the inside pass for a clear run in.

Unfortunately the need to pass is not obvious when one can see no sign of the opposition and the unsuspecting Baker was caught from behind a few yards short. To rub salt in the wound Reading promptly converted a penalty, awarded for a lineout infringement in the centre, to lead 3—0.

There soon followed, however, an amazing break from a lineout to level the scores. The mighty Cockburn outstripped all pursuers to link up with Edgar who put Kerner away for a fine try. Guy's by now had learned to contain the strong thrust of the Reading pack, and so added to their almost complete supremacy in the lineouts. They were gaining their share of the set pieces. The score was increased to 8—3 by half-time as Morris converted Kerner's second try. This followed a high kick ahead by Sharp which he somehow contrived to gather himself some twenty yards upfield to give Kerner the scoring pass.

The second half continued in like vein. Guy's continued to dominate, Reading to fight back gallantly. Allen, gathering a missed touch kick by the Reading full-back in his own half, made a fine run to the Reading line before being apprehended. Ashcroft extracted the ball to score. Bevan and Rowlands were then successful with their reverse pass manoeuvre from a scrum some five yards out and the score increased to 14—3. There followed some ten minutes in which Guy's overall control waned. Reading seized their chance and two fine passing movements plus some measure of charity from the Guy's defence were crowned with a well deserved try.

Bevan and Ross promptly ended this spell with some neat interpassing to give the former Guy's fifth try which Edgar did well to convert from far out, and Allen wound up proceedings with a thrusting outside break in the centre to race over and score yet again as time ran out.

D. J. HENDRICK

GUY'S v. TAUNTON

Away — Saturday, 16th January, 1965

Result: lost 3—0

Three days of continuous rain had produced a heavy, waterlogged, but grassy, pitch for Guy's first visit to Taunton. There was never any real prospect of fast, open rugby, for the ground was very soft and slippery throughout.

Taunton seemed the livelier side in the opening minutes and were quickly rewarded when Morris was tackled trying to clear a loose ball close to Guy's line to the safety of touch. The ball fell whence Morris had gathered it, and Hackling, following up fast for Taunton, was able to scoop it up and go over. From that moment honours were equally shared, neither side playing particularly good rugby and neither looking very likely to alter the score.

Guy's replied with some considerable pressure culminating in Sharp attempting to barge over in the corner. He was dispatched safely into touch some yards short at the expenses of Hutt, the Taunton winger, damaging a shoulder which subsequently led to him leaving the field for some thirty minutes. Morris attempted two long penalties before half-time but conditions doomed them to failure.

Taunton began the second half in much the same vein as the first. A scramble five yards out led to a miskicked clearance rolling over Guy's own line. Guy's derived benefit from any doubts regarding the ensuing touchdown, and were able to clear from the five yard scrum. Guy's then broke through with an exciting dash upfield, which was temporarily relieved by Taunton's last defender fly hacking the loose ball out of play over his own line. Taunton won the scrum, but Guy's back row caught the opposing number eight as he took the ball. Seconds later Guy's were unfortunate to hear the referee order a scrum just as Sharp wrestled the ball free to touch down. Guy's won the scrummage, but the initiative was lost as the ball was put down in the centre.

The game was concluded in much the same hard fought fashion but no further scoring chances occurred. More determined play in the early minutes might have averted this narrow defeat and is clearly indicated for impending cup matches.

D. J. HENDRICK

GUY'S v. OLD WHITGIFTIANS

Away — 30th January, 1965

Result: lost 3—11

This game was played on a bitterly cold day against a side which has had a highly successful season, losing only to Harlequins and Metropolitan Police. The backs received more than their share of the ball from the set positions, especially in the second half, but unfortunately there were a lot of dropped passes and stray passes and we were unable to cross the line.

Guy's played down a considerable slope and with a following wind in the first half, but Whitgiftians were first to score. Their number eight broke from the scrum near the Guy's line, gave it to the fly half, who did a short kick over the full back's head, and a centre beat the full back to the touch down. This try was converted. Soon afterwards, Rowlands dropped a fine goal from about 40 yards out. Thus, at half-time the score was 5—3.

In the second half, the Guy's machine worked much more efficiently, especially in the lineouts, where we got nearly every ball. Then, 15 minutes after the interval, against the run of play, Whitgiftians scored a very fine try, after

many of their men had handled the ball. The ball was finally passed down the line, and they found themselves with an overlap, and scored in the corner. In the closing stages of the game they went further ahead with a long penalty.

Guy's played well in the second half, and at all times played attacking rugby. Unfortunately, they should have kicked much more than they did in the first half.

ASSOCIATION FOOTBALL

GUY'S v. U.C.H.

At H.O.P. 20th January, 1965

Result: won 7—1

With two inches of snow covering the pitch, Guy's strode through to the semi-final of the Hospitals' Cup with a fine 7—1 win over U.C.H. Our recruit from the Rugby Club, C. J. Wright, made a promising debut, scoring the first two goals and adding a third late in the second half. The only consternation to the Guy's supporters came when U.C.H. equalised with a freak shot from the right wing, and then proceeded to play good, attacking football for the next 15 minutes. However, a goal by Cutler just before half-time enabled Guy's to change over 3—1 up, and the second half was a procession towards the U.C.H. goal, further goals being scored by Powell-Jackson, Cutler, Atkins and Wright.

J. CUTLER

HOCKEY

GUY'S v. OLD CREIGHTONIANS

16th January, 1965

Result: lost 0—1

As a result of bad weather, conditions were not good, and Guy's were fortunate that Old Creightonians allowed a game to be played on their pitch. In spite of the surface there was some remarkably good hockey played; and this nearly all came from Guy's, whose forwards in particular showed some fine passing in midfield. However, in spite of steady pressure, and no lack of chances, goals were not forthcoming; and not only once was an open goal missed from a few yards. This was strange from forwards who were generally doing well in poor conditions.

Halfway through the second half Old Creightonians scored a lucky break-away goal, which emphasised that Guy's defensive covering is not perfect—something that is certainly not easy in such tricky conditions, but even so could be improved.

Guy's continued to press, and the opposition were more than relieved to hear the final whistle. On the whole a good game by Guy's in poor conditions, with a result, which the opposition readily agreed, was more than a little surprising. There is no need for the team to be dispirited by this performance; but it did prove that goals win matches!

Team: A. Hirst; D. Loader, K. Haynes; J. Crafts, C. Brooks, P. Rushmer; R. Carruthers, S. Cripps, M. Appleby, P. Bennett, P. Brown.

GUY'S v. TULSE HILL II

At H.O.P. Saturday, 23rd January, 1965

Result: won 4—2

In this match Guy's produced some of the form which has been only too latent for most of the season. With the pitch in good condition Guy's started at a cracking pace, and Winskill, on the left wing, sent across a stream of beautiful reverse-stick centres. Within 10 minutes Guy's had taken a two goal lead, Appleby scoring from two of these centres, and narrowly failing with one from Carruthers. However, predictably the pace slackened and once again Guy's failed to use their wings and the game became more equal. Tulse Hill scored by their left wing after the ball crossed the Guy's circle a number of times, with the defence incapable of controlling it properly.

Shortly before half-time Appleby scored his hat trick from a quickly taken free hit by Brooks. At the re-start Guy's narrowly missed further goals but again play evened out. Hirst, in goal, however, had little to do, largely as a result of a fine exhibition from Loader at right back who had regained his old form. Guy's and Appleby's fourth goal was a masterpiece of direct hockey. Appleby received the ball from a 16 yard hit, passed it to Carruthers who went down the wing and centred accurately for Appleby to bang it past the advancing goalkeeper. Tulse Hill players still thought **they** were attacking! Following a long corner just before the end, Tulse Hill scored a consolation goal when their winger thundered the ball into the roof of the goal—luckily it did not pass through a Guy's player en route.

Last year Guy's beat Tulse Hill well, as a prelude to fine Cup performances; and on this showing it will have to be a very good side to wrestle the Cup from Guy's hold. The team now knows it is capable of fine performances: it is up to the players to produce it in the Cup.

K. E.HAYNES

Team: A. Hirst; D. Loader, K. Haynes; J. Crafts, C. Brooks, P. Rushmer; R. Carruthers, S. Cripps, M. Appleby, P. Bennett, A. Winskill.

FENCING

Amateur Fencing Association League, London Section:—Foil.

Guy's v. Leyton Fencing Club, at Leyton, on Friday, 17th January.

Result: Guy's won 11—5.

A very hard fought match, with little to choose between the two teams until Guy's gained a 7—5 lead.

J. Cressall fenced consistently as usual baffling the opposition with complicated attacking movements.

B. Hartley scored two splendid wins, with some fast and accurate flêching.

R. Jones used his long reach and left-handed technique to great advantage, in scoring his two victories.

Team: J. Cressall, 3 wins; R. Jones, 2 wins; C. Durant, 4 wins; B. Hartley, 2 wins.

Guy's have now had four league fixtures without defeat and stand well placed in the London Section. However, much stronger opposition, in the form of Salle Boston and Westminster City School, await us in the next few weeks.

C. DURANT

CROSS COUNTRY

On Saturday, January 23rd, there was the Queen Mary College invitation Championships at Dytchley's, in Essex, at which colleges and universities from all over England competed. The Guy's team was sadly small, and lacking the best four runners. Guy's made a slow start, and running very much as a team made their way nicely up the field. Peter Mitchell completed our number by running a determined race. As he had not run for two years, this was a fine effort.

Positions

101 E. Bowen-Jones.
109 D. Vernon.
112 A. Lakin.
117 R. Wilson.
123 P. Mitchell.

Field: 180 runners.

On Wednesday, 27th January, Guy's came 3rd in the Hyde Park St. Mary's invitation cup race. On Saturday, 6th February, the Inter-Hospitals' Cup is held over Hadley Wood, near Barnet. All support welcome, please, both runners and spectators.

E. J. BOWEN-JONES

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Registrar in the Department of Clinical Pathology,** with duties commencing on 1st April, 1965. Application forms are available from, and should be returned to, the Superintendent, Guy's Hospital, London Bridge, S.E.1., not later than **16th February, 1965.**

GUY'S HOSPITAL AND THE SOUTH-EAST METROPOLITAN REGIONAL HOSPITAL BOARD

Applications are invited for the post of **Registrar in Clinical Pathology to the Board of Governors of Guy's Hospital and the South-East Metropolitan Regional Hospital Board,** with duties commencing on 1st April, 1965. The appointment, which will be made jointly by the two bodies concerned, will be for a period of three years with duties in the first instance in the Brighton and Lewes Group, and later at Guy's Hospital. The post, which will be reviewed annually, is subject to the Terms and Conditions of Service of Hospital Medical and Dental Staff (England and Wales).

Application forms are obtainable from, and should be returned to, the Superintendent, Guy's Hospital, S.E.1, not later than **16th February, 1965.**

PASS LISTS

ROYAL COLLEGE OF SURGEONS OF ENGLAND

Fellowship in Dental Surgery

T. J. C. Hall
K. G. Isaacson
E. D. Jones
A. M. Wengraf

THE EXAMINING BOARD IN ENGLAND

Final Conjoint Examination,

L.R.C.P., M.R.C.S.

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G. J D. Moore
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P. M. A. Bowden
A. K S. Cheng
Elizabeth A. Cosgrove
D. J. Ewing
V. W. B. Franklin
*P. Garcia-Webb-Sharp
D. G. Gourley
K. E. Haynes
N. J. Healey
D. L. Ingram
C E. M. Lamb
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*H. Munitz
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G. A. Pettitt
J. D. Rogers
G. G. Stimpson
Jennifer R. Townsend
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*Jennifer A. Blyth
*P. J. R. Boyd
H. Cannell
*H. Munitz
*D. J. O'Gorman
*M. W. J. Older
*Jennifer A. Chown
*J. G. Cochrane
*P. D. Davies
*A. L. W. K. Eddleston
*C G. C. Gaches
*A. J. Hazzard
*B. H. Hicks
*C. W. Howell
*M. J. Hoyle
*J. M. I. Iveson
*T. M. Jenkinson
*Christina J. S. Lawrie
*M. F Lewis
*A. W. J. Medhurst
*A. H. Mowbray
*Jennifer P. Pearse
A. M. Roberts
*J. C Robertson
*Patricia V. Rountree
*P. J. Rowe
*P. Sheridan
*P. C. Smith
*A. Stevens
*R. A. Sturge
*I. A. Sutherland
*M. M. Walker
*M. Walter
*Dawn G. G Woodruff
*Christina M. Wotherspoon
*Rowena C. Yates

Midwifery

W. V.Annan
J. W. B. Franklin
D. G. Gourley
N. J. Healey
C. E. M. Lamb
L. Levinsky
B J. Mason
Vivienne P. Maher
*H. Munitz
L. G. Parry
T. N. D. Peet
*P. Sheridan
M. Thomson
Jenn.fer R. Townsend
A. R. M. Upton
J. J. Wallace
*Christina M. Wotherspoon

*Have completed the examination

PERSONAL

Partner required. Fee for service New Zealand General Practice. Seaside with excellent climate. Details, Mr. J. Goodliffe, Appointments Officer, Guy's Hospital, London, S.E.1.

BIRTHS

BOYLE.—On January 14th, 1965, at Halifax, Nova Scotia, to Kathleen (née Skan, S.R.N.) and Lieut. Charles Boyle, R.C.N., a daughter, Susan Elizabeth. A sister for Caroline, Andrew, and David.

BOYLE.—On January 16th, 1965, at Swindon Maternity Hospital, to Barbara and Martyn Boyle, a daughter, Cynthia Elaine, a sister for Caroline.

JOHNS.—On January 16th, 1965, at Farnborough Hospital, to Pamela (née Thurgood) and Richard Johns, a son, Timothy, a brother for Susan, Katharine, Nicholas, and Lucy.

NICHOLAS.—On November 7th, 1964, at St. Joseph's Nursing Home, Newport, to Ann (née Shackleton) and John Nicholas, a son, Antony Guy.

ZAYID.—On November 18th, 1964, at Guy's Hospital, to Greya (née Herbert, S.R.N.) and Ismail Zayid, M.B., B.S., a second daughter, Dina Petra, a sister for Caroline.

DEATHS

HANRECK.—On January 24th, 1965, at the Royal Masonic Hospital, after a long illness, Samuel Hanreck, L.D.S., R.C.S.(Eng.)., of Horsham, Sussex, in his 78th year.

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GUY'S HOSPITAL GAZETTE

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Editors *B. H. Hicks*
P. Bowden

Sports Correspondent *A. Procter*

Guy's Hospital, London

PASSIM

". . . no evidence to support it . . ."

". . . Though we do not question the sincerity of the conviction of general practitioners that remuneration has been seriously inadequate ever since 1948, we find no evidence to support it, and do not share it. . ."

Thus spake the Review Body. Thus echoed the Minister. Four hundred doctors emigrate in a year, many young general practitioners, and the number is rising. In the year ended September 30th last the number of principals fell by seventy-four. On the information available, no increase in the number of family doctors can be expected in the years 1962-1972, although in this period the population is expected to increase by about 3.7 per cent. The groups putting most strain on the general practitioner, the over-65's and under-14's, may increase by about 8 per cent and 7 per cent respectively. The profession and the journals are ringing with the discontent and malaise of general practice. But the Review Body did not hear . . . *we find no evidence* . . . the Minister does not want to hear . . . *and do not share it* . . . and thus endeth the First Lesson.

The evidence abounds that the present structure of general practice is unsatisfactory, and to many intolerable. Can Mr. Robinson really intend to ignore this? Where general practice is at stake, the whole Health Service is at stake, the very basis of socialised medicine is threatened, and this of all governments cannot discount that lightly. Quoting the Royal Commission, comparisons with doctors in hospital, remarks on the divisions within the profession, these may prove fine debating points, but they prove nothing else. In the grand and riotous surroundings of the House of Commons it may please Mr. Robinson to prove to himself that all is well with British medicine, as it pleases the ostrich to hide its head in the sand. Yet even with your head in the sand you must feel the storm around you, deny it as you will; you may even, Mr. Robinson, get kicked . . .

The question of how and where to kick Ministers who dig their heads too deep in the sand, or their hands too rarely in their pockets, is a difficult one. However great the provocation, however deep the frustration, we stand by our belief that the patient must be protected. To withdraw N.H.S. facilities without, first, explaining the exact reasons to the public in full, and second, making very thorough preparation for any interim period so that medical services were wholly maintained, would be both unethical and impolitic. The Elephant and Castle might be hit almost as hard by a refusal to sign anything other than prescriptions, or similar administrative stratagems, and perhaps these should be investigated as a first measure.

These misgivings do not stem from lack of sympathy, but genuine conviction. In terms of "sympathy" the emotion might better be replaced by "empathy", for we believe—with our correspondent (*page 84*)—that the cause of general practice has not in the past been

especially helped by those outside it, nor by those who stress its apartness from the hospital service. The divisions within Medicine are in part responsible for its present state; it is to be hoped that unified it may emerge improved, patients better served, and doctors their more contented servants.

Next time the doctors go on television (ref., *This Week,* ITV, 11th February) perhaps some of the experts could be called in. Dr. Jonathan Miller might have interviewed the Minister in a more effective manner than the sincere, but amateurish, team that was fielded.

Live Now, Pay Later

Suicide, sequel of nihilistic thought, is the last great act of defiance or despair, the only possible consequence of Judas' last kiss which tasted so bitter to his Christ. It is a problem which should concern us more than most for no less than 6 per cent of doctors' deaths under the age of 65 are from suicide—a dead-heat with lung cancer. The psychiatrist, unable to swallow his own potion, provides a disproportionally large part of this gruesome Hadean harvest, Tartarus for the believer and Elysium for the rest.

An American book, *The Cry for Help,* introduces a new aspect to the consideration of suicide, namely that of "sub-meditation", whereby certain people have a disregard for personal preservation and health which amounts to slow self-murder. The man who smokes heavily would come into this category, particularly if he continued to do so even after a coronary thrombosis. So does the grossly fat patient who knows full well the sequelae of his obesity but persists in his excess. The cirrhotic who continues drinking and the man who walks past a mass X-ray unit or the woman who never presents herself for cervical histology—perhaps, they all exhibit behaviour whose antithesis is hyperchondriasis.

Most people do not choose a particular way of life but merely exist, while others, more conscious of the world, pitch discretion overboard to walk gaily along the path of over-indulgence and early death, they fully realise their pretext, to live now and pay later. As medicine becomes more preventive, rather than curative, and as the public become more aware of medical matters, the people have a greater responsibility in affecting the outcome of their disease, and the more they fail to respond to the pointers shown by the profession, the more they limit their own prognosis.

It will give great pleasure to many at Guy's and elsewhere to hear of the appointment to the Sir William Dunn chair of pathology of Dr. C. W. M. Adams. The chair became vacant on the death of Prof. Payling Wright. Dr. Adams came to Guy's in 1958 as a lecturer, and in 1963 was appointed reader in experimental pathology. Before this he trained at Cambridge and The London, and worked at the latter hospital in the Bernhard Baron Institute of Pathology. He has also spent a year at the National Institute of Health, Bethesda.

He is particularly interested in atheroscerosis and demyelinating diseases and lipoid storage defects; he is also editing and part-writing a textbook of neurohistochemistry to be published in the near future.

We offer our congratulations to Mr. W. R. Edwards, F.R.C.S.E., M.R.C.O.G., on his appointment as Consultant Obstetrician and Gynaecologist to the Isle of Wight Group of Hospitals.

Passim having in the past castigated the Combined Round, some praise might be appropriate now. The round has recently regained much of its verve, and value, with a series of distinguished contributors and promise of more. When Dr. William Copeman came to "conduct" the round on rheumatoid arthritis, Sir John Conybeare turned up some notes he made on a round in November, 1920. There Mr. Mollison, Dr. Laidlaw, Dr. Ryle, Mr. Layton, Dr. Hurst, Sir Alfred Fripp and company concluded that "The disease is caused by chronic septic foci and that their removal, when possible, is advantageous . . . Probably oral sepsis was the most common cause". As Dr. Lessoff reminded us, in 1965, our knowledge has advanced to the point where rheumatoid is a disease "of unknown aetiology"!

A Guy's man, Mr. Ian McColl, will be delivering the Arris and Gale Lecture this year, on Thursday, 25th February, at the Royal College of Surgeons. The subject of his lecture will be "The Comparative Anatomy and Pathology of the Anal Glands".

Local colour. The four Guy's students were eating in a local restaurant, and one of them prodded at an unusually small, dark chip. Further investigation revealed this to be a fag-end (fried). The summoning of the waitress was followed by a slightly awkward silence, ended by that mistress of circumstance with "Well it isn't one of 'arry's, 'e don't smoke that make. . . ."

GUY'S DIARY

FEBRUARY.		
EXHIBITION.		*Breast Cancer.*
23rd T.	1.00	Mr. BEARD. Clinical Lecture. Anatomical Theatre. *Some Recent Problems.*
25th Th.	1.00	Dr. GRIMBLE. Clinical Lecture. Anatomical Theatre. *Neurosyphilis.*
MARCH.		
1st M.	1.00	Mr. BRAIN. Clinical Lecture. Anatomical Theatre. *Foreign bodies in the lung.*
2nd T.	1.00	Mr. READING. Clinical Lecture. Anatomical Theatre. *Tumours of the Nasopharynx.*
4th Th.	1.00	Professor BUTTERFIELD. Clinical Lecture. Anatomical Theatre.
5th F.	1.00	Mr. COOK. Clinical Lecture. Anatomical Theatre.

Personal Reflections on the Preclinical Course

J. N. HUNT
PROFESSOR OF PHYSIOLOGY

This year, more than one hundred students were admitted to the course for the second medical examination at Guy's. They are a diverse group in background, in intelligence, in academic success and in their energy. Within six years, almost all will be registered medical practitioners and within a few more years they will be working in a great variety of fields, but with the common purpose of promoting health.

The medical course should instil this common purpose at the same time as it encourages diversity and originality. It should give students the ability and confidence to employ talents which they may not discover until some years after they have left medical school.

A consideration of the purposes of a medical course requires a definition of the work of doctors. A doctor must be able to observe and record accurately. By professional knowledge, he should be able to anticipate events and should act to minimise their ill-effects. He should accept the responsibility for producing the desired result, a duty which is not discharged simply by adopting a routine which may in standard circumstances be expected usually to produce the result. He should be vigilant to see that his actions are in fact having the expected and desired effect. He should do all in his power to advance the subject. Whether or not he is acting in accordance with these principles will usually have to be decided by the doctor himself, since in maturity most of his work will be unsupervised. The capacity for self-criticism is therefore important.

To maintain his professional knowledge and a sense of responsibility for results, a doctor needs energy. During his student days a man may not be stimulated to devote himself to professional work. However, I believe that the experience of full participation in sporting and cultural life may enable him to realise that he has reserves which he can call upon for his work when he later finds a congenial professional task.

The sense of responsibility for the results of his actions, or lack of action, is something which the student may most readily learn from his clinical teachers. The preclinical teacher should not retard the student's growth by arranging his courses so that mere conformity to a system is uniformly rewarded by success in examinations. In my view it is important that the student should not be driven to work.

Guidance should not become instruction but he should be allowed to see the results of inattention to his studies early in his career. There should be sufficient free time to allow those of modest ability to digest the content of the course from day to day. The most important component of University teaching is conveyed in the arrangement of material and demonstration of ways of organising ideas and information. He should have the opportunity to experience the sequence of observation, hypothesis, experiment and interpretation which is the basis of the scientific method. The preclinical course should allow the student to develop an orderly approach to the anatomical, biochemical or physiological aspects of man. The clinical course will then be an extension of this method to the consideration of disease. Mistakes stem more commonly from failure in the orderly approach than they do from lack of information because the ordering of thoughts assists the recall of information and simultaneously outlines areas of ignorance.

Doctors work against a constantly shifting background. Common diseases become uncommon and new causes of ill-health are recognised or are created. New forms of treatment are put forward to replace the old. Patients' attitudes to their condition and its treatment change. To-day's students cannot be fitted out with to-morrow's information to treat patients with next year's diseases. The hope is that students can be persuaded to develop in themselves an enjoyment of the continuous evolution of knowledge. I believe that this should have an important bearing on the choice of material for study by preclinical medical students.

I would suggest that the material considered at the beginning of the preclinical course should be a study in depth of something simple. Harvey's account of his experiments demonstrating the circulation of the blood is an excellent example. The logical evolution of thought on the basis of experiments pursued in species chosen for their suitability for the purpose, the quantitative reasoning, and the drawing together of the facts about the arterial and the venous sides of the circulation allowing a confident prediction of peripheral communication between arteries and veins, make a good model for study.

The student should be encouraged to examine first those parts of a subject where the train of reasoning between the evidence and its interpretation can be clearly seen. Preferably the evidence should be based on physical measurements and the conclusions should be quantitative. The objective is to give the student confidence that the methods successfully applied to the study of inanimate material have the same value in Biology and by extension, in Medicine. In this way he can obtain a firm grounding in the principles of the subject.

Those aspects of preclinical subjects where there have been repeated swings of opinion, for example the study of fat absorption and the control of cardiac output deserve special attention. Here the teacher can show the student how to pick his way through the shifting sands of knowledge. The study of the distribution of gases and blood in the lung, the control of movement via the intrafusal muscle fibres, the study of the anterior horn cell and the revolutionary ideas about

the function of the visual cerebral cortex recently put forward should, in my opinion, be given special emphasis because they show how knowledge advances, and how new principles are formed. The details of these topics will certainly soon be lost but they may leave a lasting conviction that continuous study is essential to maintain professional knowledge.

So far, the emphasis has been placed on what the student should do for himself in the preclinical period, but what is the place of the teacher? In my view, the teacher's part is to provoke thought and to provide an appreciative, attentive colleague for the student. By asking questions which can be answered on the basis of simple facts, the teacher can exercise the student in their selection and arrangement. The immediate confirmation of the correctness of a line of reasoning which can be given in small classes is the most effective encouragement that can be offered. This can be supplemented by asking students to explain the implications of experimental findings presented to them. I believe the aim should be to give the student confidence in interpreting experimental results, and to allow him to realise that his ignorance is often something which he shares with his teacher. He should be encouraged to discuss academic subjects with his contemporaries.

The advancement of medicine is certainly not less important than its practice. The preclinical course should allow students to sense this by personal contact with those who are active in research. Students need to know that if they have persistent energy, application and imagination, there is an enthralling place for them to apply the scientific method in medicine. To this end the study of the scientific method with some techniques applicable in medicine during the practical course is important in allowing them to realise that there are many important basic questions which can be answered by simple methods and good experimental design.

So far, the preclinical course has been described as encouraging the orderly presentation of material, giving experience in assessing the value of evidence against some classical examples, drawing attention to the evolution of knowledge by reference to recent exciting developments, allowing the student to test his capacity to reason with the facts of the preclinical sciences, and to excite him with the possibilities of advancing medical knowledge.

At the end of every stage in his career, the student is required to write. But little is done for him to develop this capacity. From what has been said about the content of the preclinical course above, it should be clear that it will not acquaint the student with the working of all the systems which he will encounter in clinical medicine. And if it did so, it is almost certain that he would soon lose contact with the facts. If the course makes no pretensions to being comprehensive, it must contain some compensating feature. The student should be allowed to feel the power of written knowledge: not simply the power of the text-book, but the power of the journal and the monograph. In my view, Universities are not concerned with distributing a smattering of information, they exist for exciting their students with

the power of knowledge. An able student freshly prepared with facts from a scientific paper can often joust with and sometimes dismount even a senior teacher. Encouraged by the taste of professorial blood, these students will pass into the clinical period to show to what extent clinical experiences can be sharpened by a knowledge of the literature and to doubt even the most beguiling untested hypothesis. To promote study of the literature, students should be encouraged to write an appreciation of one or two subjects introduced in their preclinical course.

The present practice of taking students to see patients with physical signs explicable in physiological terms should be extended in an attempt to make the student appreciate the power of mechanistic concepts in the understanding of disease.

Any change in emphasis in the preclinical course would have an effect on the second medical examination. At the moment, this is regarded as a major hurdle by students; it demands a simultaneous acquaintance with the essential facts of anatomy, chemistry, biochemistry, pharmacology and physiology. About a quarter of the students fail at their first attempt. Those with a good knowledge and understanding of the subjects usually pass. But there are probably some whose performance does not do justice to their ability because of the large body of facts which they have prepared themselves to recall during the fateful days. As an alternative, an examination at the end of each term might be less of a burden for those whose ability to reason was not matched by their memory. To those who would say that a good memory is essential for clinical work, I would answer that memory is not likely to be developed by the ingestion and regurgitation of uncongenial material. It may be improved by the realities of clinical life.

In my view, the aim is to provide students with sets of pegs on which to hang their thoughts, to exercise students in their use, and to encourage them to follow a life of constant study. Only in this way can they be prepared to undertake rational analyses of the phenomena of clinical medicine on the basis of a changing professional knowledge.

JANE JACOBS

Jane Jacobs died on January 22nd at her home at Heathfield after a long and terrible illness. With her passing, Guy's has lost one of its most faithful daughters. Her devotion to her Training School was unbounded, and Guy's was never far from her thoughts in her professional life. Jane Jacobs had an infectious enthusiasm and a way of causing others to join her in achieving what she sincerely believed to be right and necessary for her patients and her hospital, never afraid to carry her ideas through even if sometimes it meant unpopularity with less far-sighted colleagues. Jane never allowed administrative duties to overshadow her interest in the patients, and one of her greatest joys was the creation of the Cobalt Unit at Pembury Hospital to serve those patients for whom she had always felt very special compassion. When, on the eve of taking up a cherished post at the Ministry of Health, she learned that she was suffering from a desperate illness, she took the blow with tremendous courage. To the last she kept up her interest in nursing affairs and asked for news of Guy's and her beloved Pembury. With Jane Jacobs' death the profession has sustained a loss which cannot easily be made good, and we have lost a friend and colleague of whom the Guy's family may justly be proud.

WHY TEACH GENERAL PRACTICE?

JOHN FRY,

GENERAL PRACTITIONER, BECKENHAM, KENT

Our medical schools are to some extent responsible for the crisis that now faces general practice. "Basic potential doctors" have been turned out of our medical faculties without ever having been taught anything about the problems of general practice and its techniques and with no real understanding of what constitutes "good general practice". It has been assumed by teachers, who are specialists, that no special undergraduate teaching is required on a subject as mundane as general practice and that it would be quite impossible to allow any of the students' preciously scarce time to be used in such a way.

So it has come about that in the present setting, with tremendous social and medical advances, and with ever-increasing specialisation and super-specialisation in the hospital, and when there is more need than ever for a "generalist" G.P. who can guide and protect the individual patient through the medical jungle, it is just now when the very needs for good general practice are being realised that the problems facing general practice have become apparent and the morale of general practitioners has reached its nadir.

However, there are signs that the future of general practice is bright and assured. In fact, the rôle of the G.P. is a world-wide problem. The World Health Organization has had an Expert Committee discussing general practice and its future, and has re-affirmed its essential place in medical care. The World Health Organization also has been concerned about the training of the general practitioner and has published two books recently on the subject. (*Preparation of the Physician for General Practice,* W.H.O., Geneva 1963, and *Training of the Physician for Family Practice,* W.H.O., Geneva 1963).

In looking to the future there is a need to review and to re-assess our priorities in medical education and in this there is a strong case for including teaching of general practice to undergraduate medical students.

The reasons why this is necessary, the subjects that may be taught and the methods that may be employed are now discussed, but reference should be made also to a recent publication by a Working Party on a *School of Medicine and Human Biology* (1963). (Copies available from Dr. N. Malleson, 2, Woburn Square, W.C.1). This latter publication suggests how medical education may meet present-day and future needs of the profession and the community.

The Case for teaching General Practice

Good medical care to a large extent is based on three concepts: (1) a sound and up-to-date knowledge of scientific and medical facts

and philosophies, (2) an effective system of organization of medical services involving close co-operation between hospitals, general practice and public health services, and (3) personal care for the individual by an understanding and well-trained doctor who knows his patients and their families.

Teaching of medical students has tended towards providing instruction in medical and scientific disciplines, but has tended to neglect and pay scant attention to medical care in the community outside the hospital walls, the concern of general practitioners.

It is a fact that almost one-half of all medical students eventually will become general practitioners. They receive their medical teaching on the clinical material that they see in the teaching hospitals' wards and out-patient departments. This represents a most highly selected and small segment of human disease. It has been estimated that the general practitioner copes with 90 per cent of all the problems that he is faced with, so the medical students will see only 10 per cent or less of the types of disease that occur in our community. His training will be lacking in perspectives and skewed very violently towards that small proportion of major diseases requiring hospital care.

To become a good doctor, whether he becomes a G.P. or a specialist, the student must be taught to appreciate the true pattern and nature of disease and to learn something of the ways in which disease is managed outside hospitals. Such knowledge and understanding is even more necessary for the withdrawn super-specialists than for the fledgling G.P.'s.

Some will say that this is all very well, but surely the time to learn this is in the postgraduate trainee period and that any such teaching is wasteful for undergraduates. This is false reasoning. What is suggested is that the principles of general practice are taught and demonstrated to undergraduates and the details of techniques are learnt in the later stage. For the reasons stated, all students should come in contact with and participate in the work of general practice.

The responsibilities facing the medical schools concerning the needs to improve and develop general practice in the future are further reasons why students must be shown the first-rate in their most receptive period as undegraduates. If the medical school is to teach general practice then it must become actively involved with it and set up its own units.

Yet another reason is that the teaching hospital must become much closer to its local community. For too long the London teaching hospitals have remained aloof and disinterested in what goes on in general practice and in the community around it. Teaching hospitals must become local community hospitals, interested in and participating in the maintenance of health, prevention of disease and in the management of illness in its local population. With the undertaking of teaching general practice the medical school will inevitably and unavoidably become concerned in improving local domiciliary medical standards.

What should students be taught ?

The teaching of general practice will offer much that is missing from the medical curriculum.

The *students' education* will become broader and fuller by becoming aware of the problems that face the individual and his family in times of stress and illness.

The *art* of general practice will be demonstrated by the doctor in diagnosis, prognosis and in his management of the individual, the family and the presenting illness. Especially will he see the emotional factors in ill-health and the importance of personal, family, environmental and social factors.

The *science* of general practice will be taught in the application of medical scientific principles to the situations as they occur in general practice. Early diagnosis, pre-symptomatic diagnosis, use of modern diagnostic facilities, preventive methods and health education, therapeutic principles, the patterns and natural history of non-hospital diseases and the long-term care of chronic diseases are all concerns of general practice.

The *integration of the medical services* will be shown in action for the good of the patient and the *organization* of the practice will be demonstrated also, including the use of the various auxiliaries by the G.P.

How should teaching be organized ?

Each medical school must work out its own details which must depend on local situations. For example, in Edinburgh a G.P. teaching unit was formed from an old Dispensary and in Manchester a teaching Health Centre was established *de novo*. These are at present the only two G.P. teaching units in Britain, although another is planned for Guy's.

Special planning and organization are necessary to develop a satisfactory system of teaching. Big-thinking is required and mere nibbling by a haphazard and uncontrolled system of voluntary attachments by students to selected G.P.'s is not enough.

Teaching of general practice must be based primarily on a specially planned and developed *G.P. Teaching Unit*. This unit must be carrying on general practice. It must be relatively overstaffed so that there is adequate time for teaching and the patients must be prepared to accept the students as a routine. All this is possible as has been demonstrated in Edinburgh and Manchester.

The unit at first will be attached to one of the established departments of the medical school, such as Medicine or Paediatrics, but very soon it should become autonomous and independent with full and good relations and associations with the rest of the medical school.

The unit will be under the direction of a chief or director who eventually must be granted professional status, as has been achieved already at Edinburgh.

In addition to teaching in the homes the G.P. should undertake teaching on patients in the hospital itself.

When and for how long ?

The student's time is precious and there is an urgent need to re-assess and re-establish priorities in his curriculum.

Teaching of general practice can be undertaken in a number of ways.

There may be an almost continuous part-time attachment to the unit during the whole of the clinical period; there may be an extended attachement over 3 or 6 months; or there may be an intensive short attachment over 1 to 2 weeks. All are possible.

The Situation at Guy's

The urgent need for self-appraisal and self-analysis at Guy's has been recognised. The relations between the hospital, general practitioners and the local community have been studied already by an operational research team under the direction of Professor Butterfield and supported by the King Edward VII Hospital Fund. (*Factors influencing referrals to the out-patients department of a London teaching hospital*—Brit. J. Prev. and Soc. Med—1963—17-18).

Further consideration is being given to the extent to which the hospital must go in extending its influences on the nature and quality of local medical care. The rôles of the London teaching hospitals as Community hospitals is under active review. Some, in fact, such as the Royal Free and Charing Cross Hospitals, are moving into new communities where they will undoubtedly act as foci and stimuli of the local medical services. Guy's Hospital also must consider its place in these new developments because it is now in active competition for patients and suitable clinical teaching material with other neighbouring teaching and non-teaching hospitals. Unless steps are taken there is a danger that the quality and quantity of such material may be reduced to dangerously low levels.

The *first* step must be surely for the Medical School to accept that the teaching and the study of general practice must be developed and extended. In this way students will benefit but also general practice will be helped by the fact that its problems and techniques are the concern of a medical school. The hospital will benefit also because it will come in much closer relationship with local general practitioners.

Second, if the above conditions are accepted then the teaching and studies of general practice must be planned in a realistic and forward-looking fashion with full support from the university, the hospital, the medical school, the general practitioners and the students.

Third, to carry out all that has been set out in a satisfactory manner a General Practice Teaching Unit must be established. The site and type naturally must depend on the opportunities that present themselves. Already there is active thinking on such a unit at Guy's with the possible site being in a new development area in south-east London. Such a unit must be under the direction and control of the medical school and staffed by medical men and women selected by and under charter to the Medical School and the University of London.

Fourth, whilst planning and preparation are being made for such a unit as a long-term project, teaching on general practice should be extended within the hospital and medical school. Each firm should have general practitioners attached to its teaching complement. They should accompany the firm on teaching rounds and should participate in the work in the out-patient department. They should participate automatically in symposia and seminars. Arrangements also should be made for students to follow their patients into their homes on discharge from hospital or whilst under out-patient care.

The present is a period of very active thinking about the curriculum, the methods of medical education and the organization of medical care. The problems of general practice affect us all and they must become the concern of our medical schools. Teaching and research must be organized on the conditions in and the nature of general practice. Guy's must take the necessary steps to remain in the lead in medical education and enter the field of general practice.

Annual Dental Clinical Meeting, 6th March, 1965

ABBREVIATED PROGRAMME

MORNING SESSION (10 a.m.—12 noon).

ANATOMY LECTURE THEATRE, MEDICAL SCHOOL.

11.45 a.m.	Fractures—Accidental, Incidental and Intentional. followed by a short film of the Dental Department as shown on B.B.C. 1 in "Town and Around".	Mr. N. L. Rowe (Eastman Dental Hospital and Plastic and Oral Surgery Unit, Queen Mary's Hospital, Roehampton)

DENTAL LECTURE THEATRE.

10.30 a.m.	The Role of the Oral Surgeon in Acromegaly, followed by a short film.	Mr. D. M. Macdonald

THEATRES Nos. 5 and 6 (FIRST FLOOR, NEW GUY'S HOUSE).
Operations commencing at 10.00 a.m.

There will be DEMONSTRATIONS AND DISPLAYS in all the Departments of the School.

AFTERNOON SESSION (2 p.m.—4 p.m.)

SECOND FLOOR, DENTAL DEPARTMENT.

2.00 p.m. Clinical cases will be shown by members of the Visiting Dental Staff.

DENTAL LECTURE THEATRE.

2.30 p.m. Lecture: Cases referred by Practitioners. Professor M. A. Rushton.

There will be DEMONSTRATIONS AND DISPLAYS in all the Departments of the School.

TEA will be served in the Cafeteria, East Wing, Guy's House, at 3.30 p.m.
Programmes giving full details will be available at the Clinical Meeting. Name tabs will be available for those who indicated their intention to be present.

The closing date for applications for Day and Dinner is Saturday, 27th February, *not* 30th January as printed on the application forms.

AIDS TO TEACHING

WILLIAM HUGHES

When we are considering education we are looking at the old problem of the horse and the water. How can we introduce the material into the subject?

We are at first all limited by perception. It is said that the normal range of perception is seven objects or units. The exact definition of these units remains an almost open subject. Certainly seven golf balls or seven numbers at one glance seems to fit. From the grounds of perception then it would appear that it is better to split the subject matter into perceptible sized chunks.

Given that we are to split the matter for intake, the orientation of such matter becomes all important. It is this stage of learning or teaching that governs all the rest. The order and content of each lecture or lesson, how this is taken by the subject and stored must surely govern how the material is subsequently used.

We could, for instance, learn that haemoglobin transports oxygen with an unusual form of chemical bonding. To illustrate this we are shown the full structure of haemoglobin together with the oxygen in relative position. Fine, if we happen to know what haemoglobin is! The argument might then expect us to consider the mechanism of oxygen transfer and factors which influence it. This given as a first chemistry lecture would be difficult! However, having first been presented with the porphyrin structure, followed by a discussion of bonding and spatial relations of atoms in molecules each represented in the mind by its own code, the transition to the final stage might almost take place naturally. This may seem an obvious point, but it is surprising to find the number of times things are presented in the most difficult form in the beginning.

The next important consideration after perception and orientation in this ton-up tour of learning is storage. Memory has many stages of meaning. It is now accepted that memory for mechanical skills is somehow different from memory of the brachial plexus. Whether these both share a localised section of the brain is not so certain. Is there, in fact, a permanent chemical transformation? Does the distribution of RNA change? Yes, if you like. The article is not intended to cover the theories of memory nor do most of the readers need me to remind them of the current views.

Thus our consideration of teaching and learning becomes a problem involving the best way to present material that it may readily be perceived, orientated and stored in a form which may be of use. If properly orientated the material will not only be in a state

of ready and accurate return but the returned information will have been altered. Each individual will add something of his own, in the ideal learning process. That all education is a private battle is well accepted. To be effective a teacher must guide the individual and to do this he must have contact. No matter how well the lecture is prepared in the teacher's mind when it comes to the test it is communication that counts. How much of the intended material is actually heard? How much is subsequently noted or understood? How much retained? The percentage wastage at each of those stages is enough to provide a stimulus to test the value of some lectures at all.

Communication, then, is the prime problem. Modern educational leaders have realised this and the dawn of visual aids and tape recording is with us. Piaget tells us of the gradual growth of an understanding or concept such as that of number. Most people will tell you that learning takes place as the result of secondary drive providing a stimulus. There is little doubt that learning is spurred on by secondary drive reduction. Fame and glory are a long way off but learning this technique or that gives a certain amount of satisfaction. This jumble leads us to an old concept of education—that of the unique environment. Each person, being as he is a unique product of his environment and genetical constitution, ideally needs a unique environment for his highest performance. A personal tutor for each student is even less possible to-day, however, than formerly. We are thus in the position of knowing how best to tackle the problem but little means of a practical solution. That is until Bhirrus Skinner began to make popular an idea originally belonging to a man called Pressey, who first published a report on punch board learning in 1926.

Since then, support has grown and with it an inevitable growth of conflicting psychological argument. From this two main types of of teaching machine, as they are called, have grown. One type makes use of a branching programme and is very suitable for scrambled textbooks, and the other main division uses a linear programme. Certain characteristics are common to both, however, and form the basis for teaching by means of a set of programmed information guided by a teacher. The idea is not to replace the teacher with a machine. Rather it is to give the teacher back his true job of personal communication with the student, and the time to do it. We must agree that the teacher aims to provide, not information, but a stimulation to the student to use every device available to gain knowledge. Each student has in the programme the personal extension of the teacher. Between the programme and the student may exist a unique environment. Perhaps it may be made more clear if by way of explaining the mechanism of learning by programme I illustrate how a programme is made, with ten golden rules for programmers of all ages.

1. An active response must be evoked. Either the subject must be asked to write or he may select an answer to a question posed on each segment of the subject matter as it is presented to him. This provides a stimulus to remember and, when the answer given is correct, provides an immediate drive reduction.

2. Correct cueing must be given. The subject or student must be provided with enough indication of the answer such that at least 90 per cent of people get the right answer. Overcueing is a danger to avoid, however.

3. Arranging the question in an appropriate context is very important. Saying "Daddy" is an achievement at first, but saying "Daddy" when the right man enters the room is even more desirable.

(We may pause at this stage for already we have the essence for a good frame. A frame is the name given to each small segment of information in a programme. It should evoke a response which has been previously selected, and to ensure this proper cueing to a question in appropriate context is essential. A fourth ingredient often added is Enrichment, which is a mild form of background knowledge.)

4. Proceeding in small steps is essential. Ideally one piece of information or one step in a logical argument should be presented at a time.

5. Because the argument proceeds in such small steps, it is important to get the correct sequence.

6. Frequent repetition is reassuring to most students. This must be done carefully but provides one of the more important parts of programme learning. The machine can be geared to repeat any lesson in exactly the same way ten times without losing patience or falling off in skill at delivery. Alternatively, the machine can be programmed to deliver the same lesson in five different ways.

7. A thorough knowledge of the subject matter is essential before writing a programme. Only very able teachers may have the necessary knowledge of how to get across a pure logical explanation of even the most obvious points in their subject.

8. The writer of programmes must remember not to lecture. Above all this represents the difference between the older teaching methods and programming. The introductory clouds of words are left for mass communication to those who want to hear them. The personal tutor and the student have no room for them. The programme is written to supply facts. All the matter contained in a good programme is directly relevant to the argument.

9. Never assume too much knowledge. The aim of the programme is to provide a thorough knowledge of the subject. Slightly underestimate the capacity of the group for whom the programme is intended and play safe.

10. Make sure you have plenty of time. A good programme on, for example, the heat section of elementary physics, contains thousands of frames. A programme may easily take two years for an expert team.

The whole subject is still very experimental. A programme, once written, is usually tested among a group of students and very often rewritten. After each frame the student is required either to

select an answer from two or three selected answers, or he must supply a missing word or formulate an answer. The latter method is particularly suited to numerical questions. On most machines at the present time a system rather like the old memory drum exists. The frame with question is wound into view behind a perspex window. An answer is selected and the true answer is then wound into view. In this way a record of the number of correct answers made to that particular question is easily made. The student either stabs a hole in the paper or flicks a switch at the side of the machine to indicate a correct answer. When a frame is indicated as consistently misleading students it is analysed and altered. An incorrect or non-appropriate answer is known as an error. A high error rate means revision of the programme is indicated.

S. L. Pressey has long been an advocate of "self-scoring tests". There can be little doubt that results from this method of testing show that learning from the test takes place. With a conventional test the student does not perform better as a result of the test. In this system questions are usually presented on a mimeographed sheet. The student is then required to punch a hole in a paper slip corresponding to the number of the answer he thinks appropriate. For example, if he thinks that answer three is the correct one for question two he makes a hole by stabbing the third hole in the second row of a frame. The following table of results was published in 1950 in the *Journal of Psychology*:

SUBJECT MATTER:	RUSSIAN		ENGLISH		PSYCHOLOGY	
Method of Testing	As Test	Punch-board	As Test	Punch-board	As Test	Punch-board
Median Number of errors						
1st Test	7	12	22	42	11	18
2nd Test	8	8	23	6	11	2
Decrease in error	−1	+4	−1	+36	0	+16

**Median=the point below and above which there are an equal number of cases. (Classes averaged 31 in number).*

Results of tests directed by S. L. Pressey and reprinted from The Journal of Psychology, 1950 29. The figures illustrate how it is possible to learn from a test taken by punchboard shown by decrease in errors on second testing.

Questions about the validity of the success continue to be raised. However, I think that with the mass of evidence now growing rapidly in favour of this method of easing the teaching problems posed by large numbers the dispute must be nearing its closing stages.

Just a word about types of programme at present available. That students benefit from immediate knowledge of results and that all types of teaching programme aim primarily to supply this kind of immediate reinforcement is true. Differences exist on other grounds. In 1961 there appeared in *Audio Visual Communication Review* an appraisal of the situation involving individual differences and automated teaching. This question seems to worry many people. Coulson and Silberman report that:

" Training with manually controlled machines yielded significant learning in each of the experimental groups.

Branching students required significantly less training time than fixed sequence, i.e. linear, students. No distinction was noted in the post training test.

Students receiving many items with small steps learned significantly more than students with fewer larger steps, but they needed more time.

Multiple choice training took less time than constructed response training, although they showed no significant difference in the post training test."

It seems to be the very question of multiple choice "morons" developing that evokes most criticism. However, it cannot be overemphasised that each student follows his own unique course through a branching constructed response programme. With no other form of training can he be offered, in this modern day, such unique educational training. For the future the linking of whole teaching programmes using a Bendix G-15 Computer is exciting. Already an experimental set-up of this type exists. The computer is programmed to analyse the responses made by the student and supplies appropriate programmes and correction exercises. At the same time it monitors the performance of each student. Another development includes a computer-controlled Random-access slide projector, holding up to six hundred 35mm slides.

In the experimental field the work at Harvard involving application of a programme to teach young children a sense of rhythm or colour appreciation with a view to artistic merit smacks of Brave New World.

Perhaps the time will come when *Aids to . . .* will no longer catch the eye as a haven. The prospect of an examination involving swallowing such books whole will be a thing for memories of indigestion. The multiple choice punchboard will be continually setting us right.

Christian Union.

Monday evening meetings are held every Monday at 5.30 p.m. in the North Lounge of the Students' Club. The Annual General Meeting is to be held on Monday, March 8th. Sunday evening meetings for nurses in the Nuffield Nurses' Sitting Room are at 9.0 p.m. every Sunday.

CORRESPONDENCE

General Practice

SIR,—The smug and contemptuous remarks in *Passim* of 23rd January show little understanding of the deep frustration felt by so many general practitioners under the present regime. Whatever the faults of the M.P.U. (of which I am not a member), one must recognise it is expressing a genuine opinion which is not all that far removed from the main body of practitioners, and is at least *not afraid to speak its mind without fear or favour.*

Surely it hardly needs reiterating, but—for those who have still not grasped the message—we in general practice are not asking only for a better financial reward, longer holidays, and a little time for ourselves, but more especially for proper accommodation, ancillary help, improved diagnostic facilites; briefly, the means to benefit our patients as much as ourselves. We make no apology for these demands.

It may seem incredible, but even to-day there are doctors obliged to practice without recourse to X-rays, with only limited pathological help and in totally inadequate surgeries.

(In this area covering a population of nearly a quarter of a million, only recently—70 years after their discovery—has access to a department of radiology been made available for limited use to local G.P.'s). Conditions are worst in the industrial underprivileged areas of the country and remain a legacy to the poverty and neglect of earlier years. Few hospital doctors would dream of attempting even the most minor operation procedures in the conditions many G.P.'s are obliged to accept.

This state of affairs can not be allowed to prevail indefinitely in a society which can well afford to provide something better. We are not prepared to grind on in bottom gear, our day choked with the chores of administering a free for all social service at the expense of the medical service proper for which we have been trained. General practice needs money and needs it badly, and there can be no real progress until this is forthcoming. We have been patient, but if we are to get nowhere without ultimately resorting to action, it will not be for the want of trying. In any event the sick and dying can rest assured that at no time will their needs go unheeded.

Finally, is it too much to ask that those with influence in our teaching hospitals no longer remain either ignorant or indifferent to the needs of general practice.

Yours, etc.,

D. JOHN DAVIES.

14, Neath Road,
Resolven, Glam.

From a Guest

SIR,—Although I left Guy's on 18th November, 1964, I feel it will still not be too late to express my gratitude to those who provided me with studying facilities. In particular, I mean Professor Butterfield, the Dean and other authorities. I thank many others for their friendly support. I have done my best to study so as to be worthy of the fame of Guy's, and I did quite well in the Medicine exam. in November. I am extraordinarily glad since I prepared for this exam. almost exclusively from English books, chiefly "A short Textbook of Medicine." I shall never forget those happy days among students at Guy's.

With very best wishes,

LASZLO HATALA.

Budapest.

Royal Medical Benevolent Fund

SIR,—May I draw your readers' attention to the work of the Ladies' Guild of the Royal Medical Benevolent Fund. Founded in 1909 to assist the Royal Medical Benevolent Fund in its efforts to help doctors and their families in times of distress, the Guild has increased its commitments each year. In 1963 over £26,000 was distributed in the form of supplementary maintenance grants, school fees, holidays, gifts of coal, clothing and food and in many other ways.

It has been brought to our notice that there are still many young doctors and their wives who are totally unaware of the existence of the Guild, and in consequence there have been cases of extreme hardship among young widows who did not realise that they could apply to us for help and advice.

It is hoped that this letter will make the work of the Guild known to a wider circle and will also encourage doctors' wives, who are not already members, to enrol in the Guild. Subscriptions may be of any amount from 5s. upwards, and should be sent to Mrs. Carnegie, the Honorary Secretary/Treasurer, The Guy's Hospital Branch of the Ladies' Guild at Conduit Lodge, 48, Blackheath Park, London, S.E.3, who will be pleased to give further details.

Yours, etc.,

YVONNE CARNEGIE.

Conduit Lodge,
48, Blackheath Park,
London, S.E.3.

B.M.S.A. Scholarships and Travel Abroad

SIR,—I would like to remind students at Guy's that applications may be made for the following B.MS.A. scholarships and travel awards by 22nd March:

B.M.S.A Duke Scholarship: value £150, plus free board and lodging. Duration of scholarship is three months, starting in September—nine weeks being spent at Duke University, North Carolina, and three weeks being allowed for travel. The following subjects may be studied: Anaesthetics, Dermatology, Endocrinology, Haematology, Medicine, Neurology, Neuro-Surgery, Obstetrics, Ophthalmology, Orthopaedics, Paediatrics, Pathology, Psychiatry, Surgery, Thoracic-Surgery, Urology.

B.M.S.A. Montefiore Scholarship: value £180, plus full board and lodging. The scholar may attend for any three-month period except for July and August, and will work both in the Hospital and with a General Practitioner.

Travel Grants: are to assist financially students who have made efforts to raise money to take part in vocational travel abroad.

Clerkships abroad: B.M.S.A. will arrange these in most foreign countries. Details about clerkships and Summer Schools in Scandinavia may be obtained from the B.M.S.A. representative, Tony Harrison.

All application forms may be obtained from the Secretary, British Medical Students' Trust, B.M.A. Scottish House, 7, Drumsheugh Gardens, Edinburgh, 3.

Yours, etc.,

HUGH G. STURZAKER,
President, British Medical Students' Association.

OBITER DICTA

MR. ECKHOFF (*operating, to dresser assisting*): "Come round and assist me on my other side."

(*No response.*)

MR. ECKHOFF (*again to dresser*): "Come round to my right side. You'll be more help to me there."

(*Still no response.*)

MR. ECKHOFF (*mildly irritated*): "Come round to my other side. Why don't you move?"

DRESSER: "You're standing on my foot, sir."

MR. ECKHOFF (*operating, to dresser leaning on a retractor*): "Danza"!

(*Dresser looks puzzled.*)

MR. ECKHOFF: "Danza! That's Zulu for 'Pull like hell'."

REVIEWS

CHRONIC BRONCHITIS—PREVENTION AND MANAGEMENT.

Published by the Chest and Heart Association. Pp. 71. *Price* 12*s*. 6*d*.

This short book is an account of a symposium held in November, 1962, and comprises eight essays, with a foreword by Sir Geoffrey Marshall.

The aspects of chronic bronchitis considered range from a brief and clear account of its pathology from Lynn Reid, to a psychiatrist's view of the psychology of the disease. In another essay G. Edwards gives the results of his survey of bronchitis in Leeds, particularly studying early bronchitis. The importance of environmental factors is examined; Andrew Mieklejohn, of Glasgow, discusses industrial rehabilitation, and there is a well reasoned system of management of patients with the advanced disease.

The general tone is light and simple. One gets the impression after reading several of the contributions that the information has been inadequate, but this may be unavoidable, each essay has a list of references to satisfy any further interest.

Viewed as an effort to introduce the idea of these separate aspects of The English Disease, and to stimulate further reading, the book is excellent. The essays are brief, interesting, and there is an outline of the findings of research in each field. It is not exhaustive, however, and does not pretend to be; it is not a short reference book.

JOHN BOYD

TEXTBOOK OF VENEREAL DISEASES AND TREPONEMATOSES.

R. R. Willcox. 2nd Edition. W. Heinemann Medical Books Ltd. 492pp. *Price* 70/- net.

This is a readable and well-illustrated text book of Venereology. Unfortunately its price will put it beyond the reach of most students. Venereal diseases are of increasing importance in this country and in less developed parts they merge with the Treponematoses which are also described. For many years the importance of the laboratory in this field of medicine has been acknowledged often by the setting up of separate facilities. This is shown in the text book by the very full description of laboratory procedures, and I know of no more lucid account of the W.R. than is to be found here.

As well as covering all the clinical problems of venereal disease he tackles very real problems that tend to be ignored. In such a catalogue I would place the account of the problem of life insurance cover for the syphilitic and how to run a prophylaxis centre. A duty often handed to the most junior service M.O. Following the clinical account of each disease is a comprehensive description of the different treatments available many of them pioneered by the author. This is reinforced by separate chapters devoted to the drugs used in treatment and in particular discussing possible side effects.

As well as clinical problems V.D. presents many social aspects e.g. prostitution, juvenile delinquency, and homosexuality. These are discussed and their importance assessed e.g. in one clinic over 60% of new cases of syphilis were in homosexuals; these cases are, for social reasons, the most difficult to treat effectively.

For most students this book will remain a valuable reference source to be consulted when an unusual problem arises. For anyone likely to see a reasonable number of cases it would form an invaluable addition to their library.

R. H. GORRILL.

OBITER DICTA

PSYCHIATRIC WARD CLERK (*giving history*): "The patient's husband is a long-distance lorry driver. She hasn't seen him for 14 years."

SISTER CHRIMES (*to another Sister*): " My word, Sister, you do look fierce this morning."

SPORT

At this time of the year the Hospitals' Cup competitions are reaching the final stages. All three teams, Rugby, Soccer and Hockey, are still in their respective competitions, but not without a certain amount of trouble. The Rugby team easily beat the Charing Cross Hospital 14—3, after the opponents had produced some spirited play in the first half. Guy's now play St. Mary's in the semi-final and the consensus of opinion is that the winner of this encounter will be the eventual winner of the Cup. The other finalist is the London Hospital.

The Hockey XI is having the utmost difficulty in reaching the final of their competition. Two games against Bart's have ended in goalless draws, and they play each other a third time this week. The Soccer team, as well as the Hospitals Cup, participates in the United Hospitals' League and in the University of London Cup. Guy's were joint leaders in the league, with St. Thomas's, both with 13 points from 7 games. However, when Guy's met St. Thomas's, we were beaten 2—1, and unless they lose to another hospital, and this seems unlikely, St. Thomas's should win the league. In the Cup, Guy's play St. Mary's in the semi-final. However, Guy's were beaten 3—0 in the semi-final of the University of London Cup by King's College. Although we played well in this game and held King's until 20 minutes before time, they gradually got on top and scored three goals in the closing stages.

The Rugby team has lost both its fixtures in the past fortnight. Last week-end, at the request of Coventry, Guy's went up a day early and played Coventry under floodlights on Friday evening, so that the players could watch Warwick-shire in the semi-final of the County Championship. Although only one regular first team player was playing for Coventry, they were able to field a side which included four or five county players. Coventry won the game 20—8, scoring six tries to the one by Guy's, but they started at a great pace, scoring 17 points in about as many minutes. Hereafter, Guy's more than held their own, and the score in the second half was 8—3 to Guy's. Unfortunately, the lethargic and somewhat incoherent way in which Guy's play the opening few minutes of a game has lost them more than one match this season. Last Saturday, Esher beat Guy's by 17—9. It was a scrappy game and Guy's never really got going, but they scored two good tries and Sharp dropped a phenomenal goal from the half-way after marking the ball from a 25 drop-out.

Hospitals' Cup Match, semi-final: *Guys v. St. Mary's*: *Drew* 8—8. *A full report will appear in the next issue of the "Gazette". Semi-final replay, 23rd February. Final, 4th March. Full support required*!

BLUES COMMITTEE

The following Blues were awarded at a recent meeting of the Committee:—

CRICKET

S. Davoodbhoy	Full Blue
J. Crafts	Full Blue
M. Appleby	Half Blue
D. Silk	Half Blue
E. S. Price	Half Blue

ATHLETICS

R. Morris	Full Blue
B. Hartley	Half Blue
D. Tong	Half Blue
I. Morgan	Half Blue
D. Osborne	Half Blue

CROSS-COUNTRY

P. K. Witting	Full Blue
J. Wheeler	Half Blue

SWIMMING AND WATER-POLO

B. H. Valentine	Full Blue
R. Jones	Full Blue
J. Siegle	Half Blue
D. Bartlett	Half Blue

RIFLE CLUB

D. F. Wardle	Half Blue
R. Ringrose	Half Blue

FENCING

C. Durant	Full Blue
R. Knight	Full Blue
J. Cressal	Full Blue
S. Bramwell	Half Blue

LAWN TENNIS

C. Newman	Full Blue
R. Knight	Half Blue
H. Sharp	Half Blue
J. Siegle	Half Blue

SAILING

R. Murdoch	Half-Blue

BOAT CLUB

P. Telling	Full Blue
C. Soutar	Half Blue
J. S. Gregson	Half Blue

RUGBY FOOTBALL

COVENTRY v. GUY'S

At Coventry.. 5th February, 1965

Result: lost 20—8

Because of the Warwickshire demands for the county semi-final on Saturday, 6th February, the match against Coventry was re-arranged for the Friday night under floodlights, away at Coventry. Although Coventry's was largely a reserve side, it included five County players and a blue, and to quote one report "played with dash and verve that their seniors do not achieve easily".

Coventry kicked off with a strong breeze at their backs, and it was not long before the Guy's defence was stretched to their limit. Strong running by the Coventry backs, helped by some indifferent tackling, soon gave the back row a lot of ground to cover. Indeed, it took the Hospital twenty minutes to settle down, by which time we were 17 points down with every prospect of a deluge of points to come.

After this the side got down to the game and tightened up on their mistakes. Although possession was largely the prerogative of the Coventry forwards, Coventry only scored one more try to the eight points the Hosp tal scored.

Our goal was a spectacular affair. P. Bundred intercepted a stray pass on our ten yard line, raced to the full back, punted ahead and won the dribble to the line in a great race. R. Myall added the goal points with a useful kick from half way out. R. Myall again kicked a very good penalty from a tricky angle to end the scoring.

With the advent of the final whistle a tired Guy's side left the field with the knowledge that reserve side or no they will not meet many sides that will play such hard, good rugby as this Coventry side did.

J. A. EDGAR

Team: R Myall; R. Kerner, A. Edgar; P. Bundred, J. Ross, R. Rowlands; D. Bevan, J. E. Davies, P. Ashcroft, A. Fisher, M. Cockburn, A. Kingdon, C. Neville, K. Brown, P. Williams.

1st Round, Hospitals' Cup

GUY'S v. CHARING CROSS

At Hale End. 2nd February, 1965

Result: won 14—3

Guy's overcame Charing Cross in the quarter-final of the Hospitals' Cup by a goal, a dropped goal, a penalty goal, and a try, to a penalty goal.

The approach of the Guy's side to this match was by no means overconfident. They were fully aware of the dangers of underestimating the Charing Cross side, and indeed, the first score was to Charing Cross, their full back kicking a good penalty following a very lively start by the Charing Cross pack.

Guy's then steadily began gaining regular possession from both scrum and lines-out, the latter in particular, where our second row were supreme throughout the game. The Charing Cross defence did not give one inch, and it was left to R. Myall to level the scores with a good penalty. Continued pressure by the Guy's pack then resulted in B. Rowlands dropping an excellent goal from fully 35 yards, and the sides changed over, Guy's leading six points to three.

The second half started off as the first did, with our opponents pressing. Good work by the pack then enabled Bevan and Rowlands to kick us down well into their half, from where the team launched continuous attacks on the Cross's line. From one of these, Myall came into the line enabling Edgar to go over for an unconverted try.

Exchanges were fierce; indeed, there were several injuries. Hockey received a nasty gash on his hand, and the Captain, Ian Baker, broke his nose, but continued to be an inspiration to his side by his performance.

From another attack, close to the Charing Cross line, Cockburn went over for a try, which Myall converted to round off a bout of interpassing between forwards and backs.

The end of the game came with Charing Cross, undaunted, pressing through to our line, but it was too late to worry the Guy's defence. Altogether this was a game that should have been won by more, but was a competent performance by the team.

J. A. EDGAR

Team: R. Myall; R. Kerner, A. Edgar; A. Allan, J. Ross; B. Rowlands, D. Bevan, J. Davies, J. Hockey, A. Fisher, A. Kingdon, M. Cockburn, H. Sharp, K. Brown, I. Baker (Capt.).

HOCKEY

2nd Round Inter-Hospitals Cup

GUY'S v. BART'S

At H.O.P. Wednesday, 3rd February.

Result: drew 0—0 after extra time

This was a robust game dominated by two defences capable, with a little luck, of thwarting all that the forwards could produce. Guy's team had altered slightly from that which had been so successful in the two previous games, with Liddiard returning after over three week's absence due to injury, and Strickland replacing the holidaying Carruthers. Thus, both wings were somewhat unfit; however, Strickland was soon showing some of his old skills and worked hard, as ever.

Guy's started excellently and for 10 minutes Bart's were in trouble as the ball frequently traversed their circle, although few shots were made. Following up a short corner, Cripps slashed the ball unluckily against the post; and gradually play became more equal as the condition of the pitch deteriorated. Bart's attacks, especially down their wings, became more threatening and one shot was saved on the line.

It soon became apparent that Liddiard's shoulder was far from healed; and then, still in the first half, Appleby started limping, having aggravated a ham-string injury that has caused him trouble much of this season.

In the second half Guy's continued to have much more of play, and the limited forwards did well to keep up continual pressure, Bennett in particular having a fine game. However, on several occasions there was understandably no one to slam home the loose ball in the circle, much to the despair of supporters. Twice Thomas, Bart's international right back, saved on the line, and four further short corners, although not badly taken, were unproductive Bart's, too, missed more than their share of penalty corners, and had several dangerous thrusts, but the Guy's defence covered well, and Crafts in particular did any amount of work. Passing, however, was not always accurate or thoughtful enough, and the standard of hockey not high—largely due to the pitch and a certain amount of tension that developed!

In extra time the pattern was much the same with Guy's looking as though they should score, but wouldn't; and Barts looking as though they wouldn't, but might. Thus it was with some relief that the final whistle was heard and it is hoped injuries will be healed before the replay.

Team: A. Hirst; D. Loader, K. Haynes; J. Crafts, C. Brooks, P. Rushmer; R. Strickland, S. Cripps, M. Appleby, P. Bennett, P. Liddiard.

K. E. HAYNES

GUY'S v. ST. EDMUND HALL, OXFORD

At H.O.P. Saturday, 30th January.

Result: won 6—0

This was Guy's largest Saturday victory for two years, and the score underlines their

superiority in the match. However, a little more following up in the opponents' circle could have made the score even more impressive. Guy's soon took the lead following a goal-mouth scramble, and it was Carruthers who put the ball in the net; a fitting reward for the times he has proved himself an expert at hitting the goal post this season. The first half produced little inspired hockey, and after Brooks had scored the second goal the game became even less constructive. The defence had little work to do, and the infrequent attacks by St. Edmund Hall were calmly broken up, and the ball dispatched back to the forward line. Brooks, however, had now fulfilled his ambition of scoring for Guy's, and his shot from the back of the circle must have added to his pleasure, even though the goalkeeper was unsighted. When Brooks scored the third goal soon after the start of the second half, he beamed with contentment, and his execution of the shot must have been envied by many of the forwards. The game now burst into life, and it was Bennett who relieved Brooks of the goal scoring burden. After several near misses, he finally found his direction, and no one on the field would dispute his right to the two fine goals he scored. The final goal came from Appleby, who after having a series of shots well saved, was presented with the ball by the now prostrate goalkeeper. It was too easy for a player of Appleby's calibre to miss, but the shout of joy which bellowed from Appleby as the ball hit the back board, might well have given the impression of a new player scoring his first goal, for such was his relief. The two forwards who did not score, Cripps and Winskill, gave fine support in the attack, and had a hand in several of the goals. After the disappointments of the last few weeks, it is heartening to see the team once again finding its old form.

Team: A. Hirst; D. Loader, K. Haynes (Capt.).; J. Crafts, C. Brooks, N. Turfitt; R. Carruthers, S. Cripps, M. Appleby, P. Bennett, A. Winskill.

ARTHUR HIRST

2nd Round Inter-Hospitals Cup Replay

GUY'S v. BART'S

At Chislehurst. 10th February, 1965

Result: drew 0—0 after extra time

The two sides have now played for three hours without either conceding a goal. This implies two competent defences which are able to hold up the forwards, without either side playing defensive hockey. Bart's, if anything, had the better of this episode of the encounter, perhaps because their forthright methods suffered less at the hands of the considerable tension that developed, especially in the second half.

The game started with Guy's looking considerably slower than they should have done and there was much scrappy mid-field play. Neither goal was in much danger, except when Guy's covering defence cleared off the line following a rather blatant off-side breakaway. However, apart from this the umpiring of a difficult game was good. Guy's developed a number of promising attacks but they lacked much bite; and it was soon apparent that Bart's centre-half and left-back were set for a fine game. Winskill managed to harass the right-back early on into a number of errors from which he never settled down.

In the second half play was even less well controlled and there were many very wild passes and misses by Guy's defence. One hopes not to see such an experienced defence as Guy's becoming so "rattled" as a result of cup tension and bustling unskilled opponents—surely just the time for cool level-headedness and a little thought.

Following up Guy's one short corner, Cripps pushed wide, and not long later Bart's somehow managed to clear after a centre from Strickland; but the half gradually became dominated by Bart's forwards' attacks. Once Hirst brilliantly got a foot to the ball to flick it round the post, but otherwise Guy's goal seemed in little danger in spite of a number of short corners.

In extra time Hirst was called upon to do another good save, but once again a goal-less draw became the only suitable result.

With continual thought in passing and effort to get unmarked, Guy's can definitely win the replay—they are capable of the better hockey. Thanks are due to the faithful band of supporters who competed manfully with a rowdy Bart's rugger element.

K. E. HAYNES

Team: A. Hirst; D. Loader, K. Haynes; J. Crafts, C. Brooks, P. Rushmer; R. Strickland, S. Cripps, M. Appleby, P. Bennett, A. Winskill.

BOXING

GUY'S v. OXFORD UNIVERSITY

At Guy's. 2nd February, 1965

Result: Guy's lost 1—5

The Boxing Club produced an entertaining evening on Tuesday, when interest centred mainly on their fixture with Oxford University. The University won comfortably enough 5—1, though Guy's were unfortunate to find one or two of their more promising members unmatched. In the opening bout, Hughes, after a characteristic display of energetic defence in the first round, became much the more aggressive in the second to gain a narrow points victory over Ward of Oxford.

There followed an extraordinary bout between the experienced Bethell, of Guy's, a Blue incidentally from his opponent's rival establishment, and the young and inexperienced Borgats. Bethell scored freely and skillfully at each encounter, and one wondered if the referee would intervene before the inevitable knockdown. He did not, and it was Bethell who suffered the knockdown. Borgats landed another punch that round and two more in the second before the referee decided that Bethell was spending rather too much of his time on the canvas.

In the succeeding contest, Edgar, of Guy's, mounted a fierce and fiery second round assault on Hughes, of Oxford, which left the latter dazed and Edgar near collapse. He tottered unsteadily around the ring until guided to rest by a gentle tap on the chin from Hughes. Gibson and Reynolds gave a polished exhibition, where extra weight, reach and strength inevitably secured victory for Reynolds over the equally skilful Guy's captain. Durant was sadly outclassed in his bout and the referee was once again called upon to terminate proceedings prematurely.

Guy's won their two non-match contests when the nonchalant Crawford easily outpointed his teammate, Bloore, finding time in the heat of battle to give aid to his ailing garters, much to the delight of the spectators. Powerful leading punches from Onyeama forced Hunter, of the Lynn Boxing Club, to an early retirement with a cut eye in the other "friendly" engagement.

Last on the bill was the heavyweight contest between Stansfield, of Guy's, and Watson. The extraordinary style of the Oxford man seemed to confuse, even mesmerize, the Guy's southpaw into a strange defensive stupor quite inappropriate to his usual lust for aggression so clearly demonstrated in the past in the Walworth Road. By the time he began to throw punches himself the fight was lost, though his opponent was now spent and Stansfield himself, quite unhurt, was in complete command.

D. J. HENDRICK

HOSPITAL INFORMATION

HOSPITAL INFORMATION

EVELINA CHILDREN'S HOSPITAL OF GUY'S HOSPITAL

The British Post Graduate Medical Federation will hold a week-end course in paediatrics for general practitioners and local authority medical officers entitled "THE ASSESSMENT OF INFANT DEVELOPMENT". This will take place at the Evelina Hospital on Saturday, 6th March, and Sunday morning, 7th March. Applications for a place on the course should be made to the Hospital Secretary, Evelina Children's Hospital of Guy's Hospital, Southwark Bridge Road, S.E.1, as soon as possible.

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Application are invited for the post of **Locum Medical Registrar,** with duties commencing on 1st April, 1965, or as soon as possible thereafter, and appointment until 30th September, 1965. Application forms are obtainable from and should be returned to the Superintendent, Guy's Hospital, London Bridge, S.E.1, not later than **1st March.**

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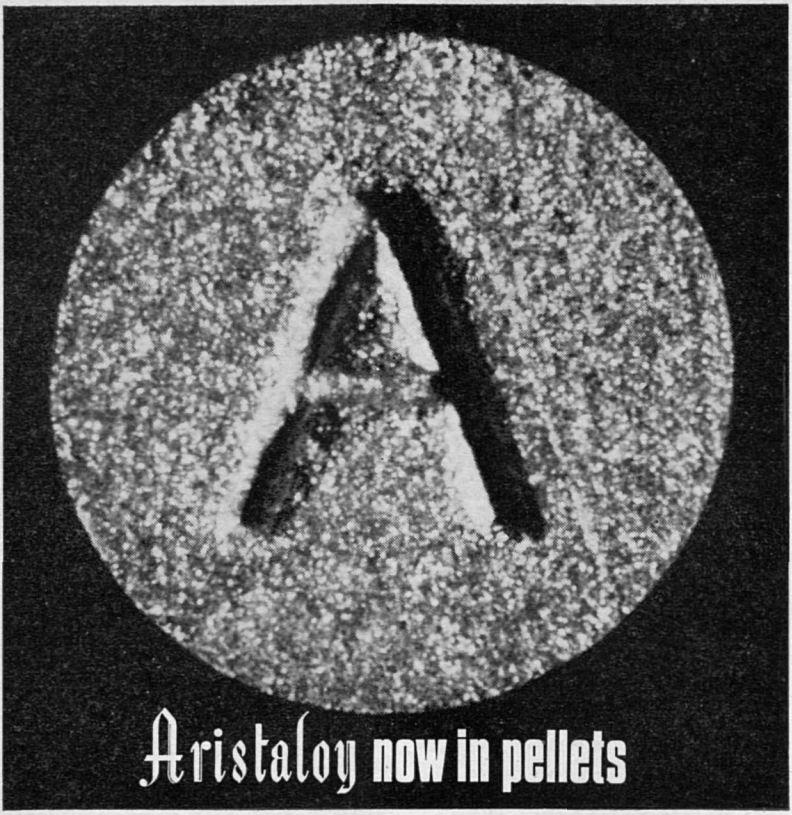
BIGGIN.—On September 4th, 1964, at Market Harborough Cottage Hospital, to Shirley (née Balmer) and Mark Frazer Biggin, a daughter, Alison Jane, a sister for Andrew Mark.

HOWARD.—On 9th December, 1964, to Shelagh (née Connelly, S.R.N.) and Peter Howard, B.D.S., a son, Andrew Michael.

NICHOLSON.—On 18th November, 1964, at Queen Mary Nursing Home, Derby, to Patsy, (née Dooley) and Thomas Wilson Nicholson, M.B., B.S., a daughter, Emma Claire Louise, a sister for James and Jill.



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Editors *B. H. Hicks*
P. Bowden

Sports Correspondent *A. Procter*

Guy's Hospital, London

PASSIM

The Student's Part

The views of the British Medical Students' Association on medical education, reported on page 98 of this issue, represent some of the first cohesive opinions passed by "the medical student" on his course. If any surprise or objection is expressed it will probably be not at the nature of those views, but the very *exstence* of them.

It may be reasonably argued that the student is in the very worst position to know what sort of knowledge or training will best fit him for his future rôle. He is less mature in personality, less experienced in the job, more influenced by short-term benefits, than are his teachers. They, the teachers, can more competently answer, "What are we to teach?" and the student's voice is perhaps best *sotto voce*. But as to "*How* are we to teach?" then no such dominance is justified.

The means of education are properly a dynamic process, of intellectual exchange, of display and retention, of challenge and answer, of facts being constantly revised, of theories concocted and theories destroyed. The very apparatus of teaching is changing, from blackboards in the past, perhaps teaching machines and television in the future. The student to-day is exposed to a novel environment, in which many of his sensory channels are threatened with saturation, gorged visually by advertising, lectured constantly by radio and television. Yet many of the techniques of teaching medicine, the "*How*" of medical education, are those of many years since, of ages and lives and students very different from those of to-day. Responsible opinion from the student is vital in the modernising of medical training. Although the authority must remain higher, the planning of medical education cannot sensibly ignore the constructive views of those to be educated.

Guy's is not lagging in this field, and a Student Education Committee is soon to be formed, to function both as a liaison between the views of the student body and the Dean's office, and to discuss problems of medical education from the student's viewpoint. We believe that this new body could do valuable service in the academic field, if the students of Guy's, the teachers, and the Committee, take themselves as seriously as these hopes justify.

Admericanisms

The subtle sophisms of the American admen slide off the tongue with nauseating slickness. *Quietude for the hypertensive. Gently, like the fall of snow, Plunk lowers the blood pressure.* Sink gratefully, my friend, into the abyss of oblivion, richly embalmed in a film of *Stunks Feminine Hygiene Powder which is formulated especially for the normal, healthy woman.* Why bother? So you stay that way . . . wait! Don't forget the "*pill*" in the *perfect pack, combining simple setting, built-in "memory" recording, push-button ease, crush-proof tablet protection, safety from small children, plus the look and feel*

of a fashionable compact, all with Eunk—E. So glad the children don't get at them, darling!

Sometimes even a *stool-softener* may not be enough, especially *when your patient complains of belching: burning: gnawing: cramping* at the pylorus: *griping: knotting: rumbling* and *knotting* at the caecum: *swelling* at the right colic flexure: *gurgling, growling, churning* and *bloating* of the transverse colon: and so on, on to the far-flung reaches of the descending colon with the horrors of *tightening, quivering, rushing* and *loosening.* Zudunk cures it all, giving *peace for the troubled gut.* However, *more physicians specify that Blunk-B is well tolerated and burpless . . .* Burp! While, elsewhere, *when doctors talk ulcer therapy they talk Slunk.* The anthropologists tell us that *it took* 1,000,000,000 *years to develop low back pain . . .* this drawback to the upright posture, this failing . . .*Klunk relieves it fast.*

With superb skill the *Punk Skinfold Caliper demonstrates to the patient that he or she is not just stout or heavy, but "fat",* wherein *a slim* (obese hypertensive) *signals to be let out . . . release him with Clunk.* In the end the direct approach wins the day, *treat what ails her, sure. Talk about the kids. Ask about Fred. Then, take a glance at her scalp. And if there's dandruff, prescribe Mulunk.* Narrator . . . rugged smile, strong white teeth and clean scalp . . . All this (in italics) and more, was read in a notable American journal, only the names of companies have been changed to protect their reputation.

The Answer is Blowing in the Wind

We still queue in both exasperation and anticipation, past the letter rack and the porter's desk to the door. Our reddened Pavlovian mucosa is paled and vanquished by the time we reach the till with a tepid plate and a cold meal. The final insult is dishwater at sixpence a cup. Spit.

GUY'S DIARY

MARCH.

EXHIBITION.		*Catheterisation.*
8th M.	1.00	Mr. ROSS. Clinical Lecture. *Cardiac Surgery.*
9th T.	1.00	Dr. F. O. BELZER, M.D. Visiting Surgeon from California. *Disease of the Biliary Tract.*
11th Th.	1.00	Dr. HARDWICK. Clinical Lecture. *Why treat Diabetes ?*
12th F.	1.00	Departmental Round. Conducted by Mr. John GRIFFITHS of the Royal Marsden Hospital, in the Clinical Theatre.
12th F.	1.00	Mr. LEWIS. Clinical Lecture. *Do you believe in Vaginal smears, Doctor?.*
15th M.	1.00	Dr. HUTTON. Clinical Lecture.
16th Tu.	1.00	Dr. MANN. Clinical Lecture. *Albuminuria.*
17th W.	2.15	Radiotherapy Tumour Conference. Guest Speaker, Mr. READING. *Carcinoma of the Larynx.*
19th F.	1.00	Professor KNOX. Clinical Lecture. *Antibiotic Sensitivity Tests.*

Commencing 22nd March, five lectures on "*The History of Medicine*".

THE GENERAL PRACTICE RESEARCH UNIT AT GUY'S

ROBERT SMITH

Dr. Robert Smith, formerly a general practitioner, has been seconded by The Wellcome Foundation to be head of the Unit which came into being on 1st October, 1964, in the Department of Medicine under Professor W. J. H. Butterfield. He is assisted by Mr. M. P. Curwen who, until recently, was medical statistician at St. Bartholomew's Hospital.

PRESENT CONCERN ABOUT GENERAL PRACTICE

General practice is passing through difficult times. There are many problems and there are no easy solutions. By tradition, Guy's has always been well orientated towards general practice and many of her graduates are at present playing leading rôles in helping to shape the future of family doctoring.

The recent official review of general practice and its future, the Gillie Report[1], based its recommendations on the belief that there would always be a need for a general practitioner service in British medicine. Few would disagree with this but it is also clearly evident from the Report and from the present surge of discontent in general practice, that all is far from well with our family doctors.

Last year the profession and the Ministry jointly set up a working party to study in detail what steps should be taken to implement the recommendations of the Report. The problems are highly complex due to the diversity of professional interests (see below) and the rapidity of advance in therapy and systems of communication which might be of use between patient, doctor and hospitals. Furthermore, much information is needed about certain aspects of current general practice which is not readily available. Above all, new methods of practice urgently need trial in the field to decide the future pattern of family doctoring. It is against this background that the new Research Unit at Guy's has emerged.

TRIPARTITE MEDICINE

The primary object of the National Health Service is to provide a system of comprehensive medical care for the nation. Of necessity, the Health Service was based on the previously-existing tripartite medical structure of the country, consisting of the hospitals, the local authority health service and general practice. The recent official report on the future of the hospitals, "A Hospital Plan"[2], and the report on the next ten years of the local authority health service, "Health and Welfare"[3], join with Gillie in stressing the need for closer integration of the three branches of the Service as essential for

the future well-being of medicine in this country. The future of general practice cannot be planned in isolation. Tripartite medicine belongs to the past and has little place in the future health arrangements of new developing areas.

THE ERITH AND WOOLWICH DEVELOPMENT

The marshes at Erith and Plumstead, together with the Woolwich Arsenal, form an expanse of 1,500 acres which are suitable for housing development. About 60,000 people can be housed there and locally employed when the area is fully developed. Planning is in its early stage and, therefore, a unique practical opportunity presents to study how to bridge the gaps that exist between general practice and the local authority services and between these and the hospitals.

The new area is being planned by the London County Council and this responsibility will pass to the Greater London Council in April, 1965. The first phase of the building is expected to begin at Erith where the low-lying and marshy terrain constitutes a major challenge to the planners.

PLANNING MEDICAL CARE

Several generations of new towns have appeared since the end of the war and the Erith-Woolwich development is expected to embody the latest refinements of these. The organic structure of a new town and its development are well described in the recent volume "The Planning of a New Town"[4]. This is the most comprehensive account available of the many factors necessary for the healthy growth of a balanced community. Housing, industry, transport, schools and social amenities are carefully planned on the basis of predicted needs. It is surprising how little attention is given in this book to planning the health and medical needs of the new community. Medical care planning is under-developed compared with planning in other fields and at times the medical and allied professions pay heavily for this. For example, our present man-power crisis in medicine arises from our failure to plan soundly for the future.

The patients who will live in the new Erith-Woolwich area are already on the London housing lists and we hope to obtain many details about this community before it arrives. On this data we will plan our health scheme.

THE MEDICAL NETWORK

Networks of transport, electricity, shopping, schooling and many of the other essential features of modern towns are built into development plans at the earliest possible stage. We are proposing that a medical network be added to the plan, a logical fusion of general practice, the local authority and occupational health services with proper linkage between these and the consultative and diagnostic services provided by the Regional Hospital Board and Guy's.

The scheme will be phased to provide the necessary services from the arrival of the first newcomer, in two or three years' time, until the whole area is completely developed about fifteen years later. From the time the scheme begins to operate, Guy's will be able to use it for teaching and research purposes.

THE HEALTH CENTRE

Our initial task is to plan for the needs of the first 10,000 patients. The services will be centralised in one building where a group of five or six doctors will practise. The doctors will be helped by secretarial and nursing staff as well as by welfare and social workers. Patients will register with doctors as at present, but in the first place individual doctor's lists will be restricted to a maximum of two thousand patients.

Each doctor will supervise a team consisting of midwife, home-nurse, health visitor and welfare worker. Certain diagnostic facilities will be available at the centre and it is hoped that special sessions will be arranged when patients can be seen by their own doctor and local hospital specialists in consultation. Part-time hospital attachments for the centre doctors will be encouraged and it is hoped that individual members of the group will have special interests in obstetrics, paediatrics, psychiatry, geriatrics and occupational health.

HEALTH PROMOTION AND PREVENTIVE MEDICINE

Ante-natal and post-natal care and infant welfare will be undertaken at the centre as will routine examination of school-children and the elderly. Screening for pre-symptomatic disease will be carried out and techniques of health promotion will be studied. The aim will be to maintain a common-sense balance in the patients, between awareness of health dangers and undue anxiety over health matters.

Occupational health is an important medical feature of any urban industrial area. The pattern of local industry will be studied and the problems arising will be seen as part of the overall preventive medical needs for the area.

We anticipate that dentistry, family planning and other special services will also be catered for and included as our plans develop in detail.

DAY CENTRE AND SPECIAL UNITS

We hope that a Day Centre will be built in addition to the Health Centre. Here the elderly from home or recently discharged from hospital can choose to spend their time usefully in the company of others of their own age. Meals, light work, occupational therapy, and physiotherapy will be available. A day-nursery will provide care and supervision for the younger children. As the numbers living in the area grow, provision for the needs of other special groups, e.g. the physically and mentally handicapped and the social misfits, will be studied.

EDUCATION AND RESEARCH

The Medical School, as the intellectual centre of medicine, creates the doctors of the future, and, therefore, should have a greater part than it has now in helping to shape the future of medicine.

Interest in general practice and its problems is spreading. This is good for general practice. General Practice Units already exist at

Edinburgh and Manchester and others are being mooted in several other London teaching hospitals. There is an increasing acceptance of the fact that hospital medicine is only a part of the story of health and disease. Much of the rest must be sought in the patient's home and place of work.

The General Medical Council has announced that it is to undertake a major review of the medical curriculum. The place of domiciliary medicine in undergraduate teaching is a matter of much debate, as is the question of providing greater opportunities for vocational training in general practice. We hope that the link between Guy's and the developments at Erith and Woolwich will help to solve some of these problems.

GUY'S AND COMMUNITY MEDICINE

Guy's has a distinguished record in its teaching of social medicine and for years has run a well-established student-attachment scheme. The Out-Patient Study and the Bermondsey and Southwark Health Survey undertaken by the Department of Medicine have thrown light on the rôle being played by Guy's in serving its local community as well as giving much information on the morbidity in surrounding areas. The diabetes survey at Bedford demonstrates the value of a large-scale co-operative venture to investigate a single disease. The Erith-Woolwich scheme, embracing the wider field of general practice, is a further step forward.

Much more work remains to be done. Professor Butterfield and I have had meetings and discussions with the many interested professional and lay bodies involved. We have been very encouraged by the interest and support of the Dean and School Council and Guy's Hospital Authorities, and by the goodwill and offers of collaboration which we have received from various distinguished people in local and parliamentary government, medical, architectural and planning circles. We have had most valuable meetings with the Local Medical Committees of London and Kent, the Executive Councils of these areas, the College of General Practitioners, local B.M.A. Divisions, the Regional Hospital Board, the local hospitals and the London Borough Medical Officers. It has been agreed to form a liaison group representing these many interests which will mean that when our final plans are completed a new machinery will exist whereby these plans may be implemented.

The task we face is far from easy, and we may fail to achieve all our ambitions, but Guy's is demonstrating in a practical fashion how a medical school can make a contribution towards solving some of the problems that confront general practice.

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[1] The Field of Work of the Family Doctor. Report of Sub-Committee of Central Health Services Council. Ministry of Health, H.M.S.O. October, 1963.

[2] A Hospital Plan for England and Wales. Cmnd. 1604. H.MS.O. January, 1962.

[3] Health and Welfare. The Development of Community Care. Cmnd. 1973. H.M.S.O. April, 1963.

[4] The Planning of a New Town. London County Council. 1961.

Educable Basic Doctors

HUGH G. STURZAKER

PRESIDENT, BRITISH MEDICAL STUDENTS' ASSOCIATION

Following discussion in the Medical Schools on "Medical Education 1964", prepared by the British Medical Students' Association's Education Officer, a conference was organised in Birmingham by the Association on 9th and 10th January, 1965, at which representatives from all but four medical schools in the United Kingdom were present. The Special Committee to review Medical Education established by the General Medical Council has asked B.M.S.A. for "suggestions and ideas" about Medical Education and along with the resolutions passed at the Conference the Association will be submitting evidence to the G.M.C. Below is a short account of the Birmingham Conference. The Committee, which was elected at a general meeting of Guy's Medical Students in November, appointed Michael D'Souza to represent its views in Birmingham. Also present at the Conference were Stephen Robins, Vice-President and Director of Publications of B.M.S.A., and the author.

Before considering how to improve medical education it is necessary to realise that medical knowledge has increased so greatly during the last few decades that methods which produced admirable doctors thirty or more years ago are no longer suitable for producing doctors in the second half of the 20th century. The extent of medical knowledge is so great that no longer is it possible for one person to digest it and, even if he could, much of what he learnt would be out of date within a few years. Consequently, the aim of medical schools must be to produce doctors who have been presented with the basic facts required to practise medicine and who have developed the ability and the desire to continue their own education whether it be in cardiac surgery, paediatrics, general practice or other speciality. "Finals" are but a stage in a lifetime of education and medical schools must aim at producing "Educable Basic Doctors".

Integration

Unanimously aware of this concept, the delegates to the Conference decided that the best way of imparting knowledge was by integrating the teaching of the different departments, particularly in the pre-clinical years. Too often the staff try to produce anatomists, physiologists or biochemists, and fail to remember that they should be educating the *average* medical student. Admittedly, the student should be given an insight into research and have his mind stimulated by examining a subject in depth, but to attempt to do this in each of the subjects of which he needs to have some knowledge in order to become a doctor is not only foolish but also futile.

Although integrated teaching of structure and function would require a great deal of planning—and sacrifice—by the various departments it was recommended that teaching should be by systems as has been started in Newcastle, and done successfully for 14 years at Western Reserve. Thus in a space of a few days or weeks—depending on the subject—the student should have a comprehensive picture of a system, e.g. with the liver the anatomists would deal with its embryology, anatomical relationship, histology, blood supply, etc., and this would be followed by tuition in its physiology and biochemistry, coupled with the demonstration of a few patients from the wards with various forms of liver disease. The student would then realise the importance of Liver Function Tests, etc., and take greater interest in textbook theory and the practicals performed in the laboratories.

Such an arrangement would help break down the division which exists between the pre-clinical and clinical parts of the training and it was urged that that great hurdle—the 2nd M.B. examination (and its equivalents)—should be critically re-assessed. It was thought that smaller periodic examinations—some of the multiple choice question type—would promote more even working throughout the course and prevent a few weeks of frantic memorisation of soon forgotten facts—which cannot be called education—before the 2nd M.B. examination.

Comments on some subjects

In such a conference it was impossible to go into detail on many topics, but it was thought that in most Medical Schools time spent on *anatomical* dissection could profitably be reduced in favour of, e.g., demonstrations of living anatomy and tutorials on prepared specimens. More time could be devoted to the rapidly expanding subject of genetics, and to the study of elementary statistics. Courses on Speed Reading and on the basic principles and applications of Medical Electronics could also be useful.

Tuition in *psychiatry* was considered difficult because so much of it depends on unproven hypothesis, resulting in many students turning away from its intangibility to the more easily explained somatic (sic) medicine. To prevent this, tuition should be given in easily negotiable stages and throughout the whole of the Undergraduate Medical course, starting with psychology in the first years and gradually incorporating psychiatry throughout the Clinical period.

Introductory courses ensuring the competence of the student in the basic principles of his future hospital work, e.g., history taking, examination of patients, etc., should be universal. Many of these courses were considered too short (some lasting 10 days) or too long, and 6-8 weeks was considered adequate. A course on nursing techniques was also thought important but the delegates were adamant that the student should not become "general factotum" of the nursing staff.

The isolation of *pathology and microbiology* tuition was deplored, and although general pathology and microbiology needs to be taught

before working on the wards, clinical pathology teaching should form an integral part of the clinical course. Although the conference was in favour of students performing simple investigations on the blood, faeces, urine, etc., of their patients it was thought that this should not be compulsory during the latter part of the course as there were many ways in which time could be better spent. Attendance at, and assisting with, more complex investigations was also encouraged. More emphasis on treatment was urged and it was suggested that "Therapeutic Rounds" and "Clinico-Therapeutic Conferences" would help with this.

Away from the Teaching Hospital

Considering the scarcity of the more common diseases in the Teaching Hospital and the low patient/student ratio in most of them, which will be reduced even more with the increased intake of students without a corresponding increase in the number of Medical Schools, there was unanimous agreement for the secondment of students to non-teaching hospitals for periods of about two weeks during each medical, surgical and special appointment. Another advantage of such secondment is that the student is usually given far more responsibility for his patients than in his Teaching Hospital, and this is a trend which needs to be encouraged. The idea of having elective periods of at least two months duration—thus permitting travel abroad—was also adopted.

Departments of General Practice

There was great discontent about the poor contact between the medical student, general practitioners and local Officers of Health; thus it was recommended that Departments of General Practice should be established in all medical schools to alleviate this problem and to ensure that the medical student was furnished with adequate knowledge of social and preventive medicine, and of the part played in these fields by the different authorities. To enable the student to obtain some insight into general practice it was agreed that during his clinical training he should reside with a G.P. for at least two weeks and, because of its importance, that this should be a compulsory part of the course. The delegates also wanted students to witness and perform deliveries "on the district" during their midwifery appointment.

Teaching Methods

Methods of teaching came in for much adverse criticism and there was dissatisfaction with the poor level of teaching in many instances. It was thought that lectures were not the best way of imparting knowledge which was already in the textbooks and for this reason and the poor standard of many, attendance at lectures should be voluntary. A signature is no proof of attendance and certainly no indication that a person is understanding what is being said—even if it is intelligible to the lecturer. More tutorials, clinico-pathological conferences and other methods of encouraging greater student participation and the appreciation of the unified concept of the normal and the disease process are needed together with the greater use of visual

aids, e.g. diagrams, slides, films and closed-circuit television. Teaching machines could be helpful, as has been shown in Newcastle with the teaching of electrocardiography, and it was hoped that their application would be further extended.

The evidence of the 1962 survey, undertaken by the Association for the Study of Medical Education, was still considered valid, and the delegates felt that medical students required more information on what and how to study. They therefore recommended that they should be provided with tutors, i.e. an adviser in academic and personal problems.

Degrees

It was hoped that integrated teaching would remove much of the incoordination which exists, so resulting in better understanding of the subject. However, the delegates were conscious of the dangers of medicine being presented to them on the proverbial plate, and, realising the importance of producing "educable" people, they were greatly in favour of more medical students being encouraged to study one of the pre-clinical subjects in depth for a year, at the end of which they would sit a degree examination. This would have the advantages of other university degree courses and would enable the student to become acquainted with the principles and techniques of research. Although it would tend to split the medical course into pre-clinical and clinical periods it was thought that the advantages would outweigh the disadvantages.

The ideas of Dr. Malleson and his working party for a three-year degree course in Human Biology in place of the pre-clinical course was well received and it was hoped that Keele University would be able to put the plans into practice.

Incompetent Students

Everyone present at the Conference was well aware of the incompetence of most Medical Students when faced with people who have been involved in an accident and it was hoped that Medical Schools would provide modified courses in First Aid which would be undertaken by students, preferably before they start on the wards.

Accommodation

The physical factors which hinder the mixing of medical and other university students—especially in London—were deplored, and a step towards improving this situation was incorporated in a plea for more accommodation taking students of all faculties. The plight of the married student and junior members of hospital staff was also appreciated and an increase in married quarters was requested.

Postgraduate Training

With the incorporation of the suggestions decided upon by the delegates, they considered it feasible that the undergraduate course, not including the degree course, could be reduced in length and that the pre-registration period should be correspondingly increased. The

conference thought that at least one of the pre-registration house jobs should be undertaken outside the teaching hospital and that house jobs on a four month rotating basis should replace the present system. In addition it was considered essential that people wishing to continue working in hospitals should spend some time in general practice during their first post-graduate years, and that more opportunities should be provided for married women doctors to continue practising medicine.

Author's Comments

While none of the above recommendations could be described as revolutionary—many people have talked too much for too long about Medical Education for there to be anything new—it is important to note that the delegates (who came from almost every school in the country) agreed by large majorities, and often unanimously, on all the points outlined above. Although many have been instituted in many schools it was surprising and alarming to hear of the situation existing in some schools, e.g. in one, students have to choose between doing a psychiatric and a neurology appointment.

It was my hope when I started preparing "Medical Education 1964" that it would act as a basis for further discussion. This started after the B.M.S.A. Annual General Meeting in Dundee in November, 1964 and culminated in the Birmingham Conference, where the absence of Staff Student Liaison Committees, or their equivalents, in some Medical Schools was deplored. This charge can no longer be levelled at Guy's, for the formation of a Student Education Committee has been sanctioned. It is hoped that students will give it every support, so that the Staff may be helped in further improving the medical training at Guy's.

IAN M. SHARPE

Dr. Ian M. Sharpe was at Guy's from 1945 to 1950. He and his wife Audrey, and their three small children Alison, Jillian and Andrew, were killed by the rebel forces on or about December 15th, 1964, at Banalia, Republic of Congo. Dr. Sharpe was 37 years old and had been a missionary with the Unevangelised Fields Mission since December, 1956.

WILLIAM DUNN EVANS

I cannot let the passing of Dr. Evans go by without adding my small tribute. I have known Bill Evans for nearly thirty years, from the time that he was a promising young student at Guy's. A brilliant future lay before him in his chosen field of pathology, to which he was dedicated. He was endowed with a dry sense of humour, which remained with him to the end, and this added to a kindly disposition with infinite patience, endeared him to his students and colleagues alike. His career was marred by a long and distressing illness which he bore with courage and fortitude, and through which his wife Joan sustained him with cheerfulness and bravery equal to his own. A loyal and true friend, his death at an early age and at the height of his career is a great loss to his many friends and colleagues.

Disenchantments

MICHAEL A. SIMPSON

While it has long been realized that an organism learns chiefly by the changes it produces in its environment, it is only of recent years that it has been recognised how these changes may be manipulated. The concept of "reinforcement" has arisen, rather akin to Thorndyke's "Law of Effect": that those bonds between a situation and responses which produce a satisfying result will grow stronger; while those between stimuli and responses producing annoying results will tend to become weaker. A satisfying result was defined as a condition which the animal does nothing to avoid, and often takes steps to maintain; an annoying result, as one that the animal does not try to maintain, and often attempts to end.

Using reinforcement techniques, Skinner showed that they could shape the behaviour of an organism "almost at will". By presenting food to a hungry pigeon at the right time, various responses (stretching the neck, stamping the foot, pacing a figure of eight) could be built up, changing the contingencies of reinforcement in the direction of the required behaviour. Reinforcements continue to be important, even after the organism has learned—they are needed to maintain the behaviour in strength. Comparable results were obtained with pigeons, rats, dogs, monkeys, human children, and, more recently, with human psychotic subjects.

What reinforcements are used in education? Not long ago, educational control was openly aversive. The child read, wrote, and calculated, to escape the threat of physical unpleasantness—he learned, so as to avoid punishment. Many people have observed some results of such Dickensian methods in themselves: the sight of a complex algebraic formula is likely to set off—not mathematical behaviour—but a reaction of anxiety, guilt, or fear. Then in a flurry of educational reform, Dr. Arnold's hallowed precepts were swept away. But the system replacing it is not so very different. The child at his desk, applying himself to the Wars of the Roses or the Coefficient of Expansion of Cadmium with such unnatural fervour, acts—not under positive control, but merely under the threat of another system of aversive events—the teacher's displeasure or anger, criticism or ridicule from his class-fellows, low marks, poor showing in the competitive examinations, a trip to the Office to be talked *through* by the Headmaster; or even a complaint to the parents, who may still be backward enough to resort to the cane . The positive reinforcement resulting from getting the answer right is swamped in anxieties and aggressions.

What positive reasons can you offer the pupil for studying? You might point to the final advantages of a good education. But no matter how much he might *want* to become a doctor, he may still find it impossible to memorize a page of biochemical formulae. Sheer manipulation of the environment is reinforcing—children can play for hours with scissors and paper, rattles—anything which feeds back changes in the environment, and is moderately free of aversive overtones. Recent research has shown that the net amount of reinforcement is relatively unimportant—a very slight reinforcement used properly, and at the right time, may be extremely effective in controlling behaviour. Saltman showed that a delay in reinforcement of only six seconds could produce a 50 per cent increase in errors. The gap between behaviour and a far off consequence can be bridged by a series of "conditioned reinforcers", hence the marks, diplomas, medals and other facetiae, used to signalize progress through education. By making each successive step as small as possible, as is done in programmed learning, the frequency of reinforcement is raised to a maximum, which explains the success of such teaching methods.

Of course, the positive reinforcement must be related to the student's behaviour in the right way. Erasmus tells of an English worthy who attempted to teach his son Greek and Latin without punishment. The boy shot at targets shaped like Greek and Latin letters; each hit was rewarded with a cherry. He was fed with delicious biscuits cut to the shape of the letters. As a result, I suppose the boy salivated on being presented with a page of the Greek New Testament, but it is unlikely that his classical knowledge increased. Similar misdirection is apparent in the design of some exciting, colourful—and distracting—American textbooks.

The more one studies education, the more one is appalled at the way in which much educational experimentation is carried out. During my years at school on two continents, I have been subject to the experimental whims of a generation of educationists, and despite their best endeavours, have managed to educate myself in the progress.

Any doctor who dared suggest experimenting on children, with as little knowledge of the possible results of his actions as an educator may have, would not be allowed to practise.

Examinations are being designed, and used, and are steadily gaining in importance. Yet do the examiners pause to consider exactly what they are trying to do? A proper examination system appears to me to be one which is optimal for gaining the information needed to achieve a specified form of control over a system, particularly control over learning. Mere factual knowledge, like the knowledge of a student who can achieve parrot-like repetition of the formulae used in roof design, is of little lasting value. It may be argued that parrot-like repetition is required, but the need is largely an artefact due to the method of examination. Tape-recorders, computer memories, and books of reference can beat any man at mere repetition; human beings should be used for a purpose for which they are better adapted. Surely it is the *use* rather than the possession of knowledge that is important.

Generally, when we consider measuring a system, we assume it to be in a meta-stable or quasi-stationary condition. One does not attempt to measure the width of the pelvic outlet of an Olympic athlete as she thunders past. We are hardly likely to achieve a steady state in a child on saying, "This is your Examination Day—your future depends on these results", except in those too phlegmatic to be moved by any occasion. Some students never do themselves justice in examinations, others may be lucky enough to be in radiant health, and to have studied just the right things the night before. To a large extent, the faculty tested by many major examinations is the highly specialized training the children were given to pre-condition them to the experience of being examined. The child who does well in his history exam. is good at passing history exams., but may make an abysmal historian.

Examinations have been designed for various purposes, and have been put to various uses:—

(1) As a means of maintaining standards. The examinations for entry into the Chinese Imperial Service, which continued almost unchanged for 1,500 years, are an example;

(2) As a basis for licensing—like the driving test. The final examination in medicine seems to fit into both these categories, as may 2nd M.B.; although some students wonder if the ability to determine the Saponification Value of an Ester is so important to clinical practice as to necessitate examination on this point;

(3) As an adjunct to inspection, giving the Education Authorities some idea of the effectiveness of the school—general low marks might indicate poor teaching, or poor students;

(4) As a device for stimulating effort, using the desire to succeed in exams. If some students are noticeably to succeed, however, others must fail, and *their* effort is not always stimulated;

(5) As administrative devices, such as the 11-plus, to present secondary school teachers with more or less homogenous groups of pupils; and

(6) As tools of social engineering, to "break through class barriers and speed social mobility". Almost anyone could enter the Imperial Chinese Exams. (except, of course, the immediate children of play-actors, executioners, and nail-cutters).

Early methods of examination, like those put forward by Bentham, might not gain much support to-day—although the reliance on memorisation of the only acceptable answers is not foreign to the students in other countries. The written essay type of examination was welcomed as a final answer to the weakness of earlier systems—it was impartial (all candidates were measured by the same standard); just, giving the pupil better opportunity to display his capacity; and there was no possibility of favouritism. Various disadvantages in the Essay-type examination were soon apparent. In America, in the earlier half of this century, and with steadily growing momentum, batteries of Aptitude Tests, True/False Tests, and Multiple Choice

Tests (as later varied in Punch-Board and "Self-scoring" Tests) were devised. Various authorities, unhappy with essay-type examinations, embraced these new testing techniques with wondrous fervour.

But the Disenchantment has set in, and the faults of even these systems are now obvious. While we in Europe zestfully adopt these techniques, in America they begin slowly to lose ground. In general, we have been no more successful in devising a test predictive of ability than were the Imperial Chinese. The examination system which crystallized during the T'ang and Sung dynasties, remains yet familiar to us.

Gowland Hopkins, Pioneer in Radiology

Last October the Gazette published an article by Professor Allsopp on "The Development of Radiology". Professor Allsopp has recently come across the following reference to F. Gowland Hopkins, which shows that X-rays were being used at Guy's even before 1897.

For the privileged position I occupy to-night, I can at least claim one qualification, namely, that the span of my professional life coincides almost to a year with the history of radiology so far as it has yet been written. In 1896 the present Sir Frederick Hopkins, then on the teaching staff of Guy's Hospital, as an enthusiastic amateur of the new science, had acquired a primitive X-ray set. At his request, and in my capacity of house-surgeon, I collected a group of five cases supposed with varying degrees of probability to have needles embedded in their hands. As the screen had no dark camera attached, it was necessary to turn the gas very low, ignoring the offensive fumes which the Argand burner under such conditions produces. Moreover, the insulation of high tension wires was at that date absent or imperfect. The demonstration was successful; an embedded needle was clearly seen in every case, and was marked upon the skin. In other words, five cases, previously undiagnosable, were diagnosed by the new method. The patients were told to come up for operation next day, but not a single one returned to the scene of the diabolical dark seance at which he had assisted, where in a dark and evil-smelling chamber there had appeared before him a mysterious green globe of light, the operation of which was attended by painful electric shocks and the awful vision of his own skeleton.

" *Radiology from a Surgeon's Standpoint—*11*th Silvanus Thompson Memorial Lecture.* W. Sampson Handley, M.S., F.R.C.S.—November 15th, 1928. Brit. J. Radiol, **2**, 50 (1929).

Student Education Committee

The elections for this Committee will be held on March 16th and 17th, and details of the Committee's Aims and Constitution, nomination forms, and ballot papers, will be distributed *via* the letter rack, East Wing. The interest of ALL medical students would be particularly valuable at this stage, as a gesture of confidence in the new Committee. *The Committee will be fully independent of all other clubs and societies at Guy's.*

CORRESPONDENCE

General Practice

SIR,—It would appear that doctors have belittled their cause and have lost some sympathy and respect from the public by basing their dissatisfactions on remuneration only. Doctors themselves may understand that their troubles are not wholly monetary, but the public needs more information to help them realise what they have lost in the service doctors used to provide, and how much the National Health Service leaves to be desired. Without drawing any red herrings across the path to higher salaries, surely the better way of stating their case would be " Improved conditions for the patient, plus proper status and remuneration for the doctor."

Yours, etc.,

M. S. GRIFFITH.

Mawgan Porth, N. Cornwall.

Sister Falwasser

SIR,—Like " many thousands of other Guy's nurses and men", it was with great regret that I read of Miss Falwasser's forthcoming retirement, although I realised that it was imminent. What an outstanding example " Sister Job " has been to us all, and what a comfort and consolation to the many patients whom she has nursed. I have yet to meet a nurse with a greater sense of humility and dedication; she is the epitomy of the motto *dare quam accipere.*

I send her my thanks for her loyal support and many helpful suggestions in connection with the planning of New Guy's House, and in the training of student nurses during my term of office. She has my very best wishes for good health and happiness in the active years of retirement ahead.

Yours, etc.,

JEAN RECKNELL.

Chantry Green House,
Steyning,
Essex.

Miss Mower White

SIR, On May 2nd, after forty years' continuous service, Miss Mary Mower White retires from the staff of Guy's. During the whole of this time she has worked in the Superintendent's Private Office in a secretarial and administrative capacity and has been of the greatest help not only to four successive superintendents, but to the Hospital and the medical staff as a whole. She has been an invaluable source of Hospital information, and many over the years have freely consulted her and obtained her willing help. Now that the time has come for Miss Mower White to retire to a cottage recently acquired in Cornwall, it is thought that Guy's consultants past and present, also many Guy's men and women who have left the Hospital, would like to contribute to a farewell gift. Cheques should be sent to the Superintendent and marked " Personal."

Yours, etc.,

J. B. BLAIKLEY,
Superintendent.

Guy's Hospital, S.E.1.

Science Club

The next meeting of the Science Club will be held in the Committee Room in the Medical School on Wednesday, March 10th, 1965, at 4.45 p.m. Dr. E. H. Grant, of the Physics Department, will speak on:—

"Investigation of the structure of biological macromolecules".

The chair will be taken by Professor C. B. Allsopp. Tea will be served at 4.30 p.m. in the Staff Common Room. A cordial invitation is extended to all members of the teaching and research staff of the Hospital and Medical and Dental Schools.

R. O. WELLER (*Hon. Sec.*)

REVIEWS

REVIEW OF GROSS ANATOMY,

by Ben Pansky, Ph.D., and Earl L. House, Ph.D., The Macmillan Company, New York. First edition, 1964. Pp. 443.

This paper-backed volume, by two science-qualified professors of anatomy in New York Medical College, is sub-titled " a dynamic approach". There is nothing particularly dynamic about the approach, which is regional, and pays about as little attention to function as do anatomical texts in common, despite claims in the preface. Every part of the text is faced by appropriate line drawings, and this excellent arrangement is heightened by the high quality of the drawings. The text is terse, didactic rather than explanatory, and is frequently no more than a list of the structures depicted on the opposite page. The illustrations are over-burdened with captions in many cases, and the sheer burden of trying to absorb their details is in no way alleviated by the uninspiring text. True, there are clinical applications listed, but the overall effect is as soporific as in most books of anatomy. The volume is intended for medical and dental students, postgraduates, physiotherapists, and even nurses (!). For any of these who require a technical catalogue of the human body, this is a useful book.

R. WARWICK.

FORENSIC MEDICINE.

Fifth Edition. Keith Simpson. 1964. London. Edward Arnold Ltd. Pp. 356. Figs. 138. *Price* 37/6*d*.

Since the appearance of the first edition in 1947, Forensic Medicine has appeared in new editions or has been reprinted about every 2½ years. This reflects its demand by members of the medical and legal professions. The newest edition maintains all the features which have made it the most popular book on the subject, and will undoubtedly be received as enthusiastically as its predecessors.

In the fifth edition not only has the law been brought up to date and more recent cases introduced, but the chapters on poisoning have been almost entirely re-written, prominence having been accorded to the more common and newest poisons and the rarer poisons occupying less space. It is remarkable that after five editions with all the amendments due to changes in legislation, the increases in the numbers of scheduled poisons and the revisions of different sections to bring them completely up to date, the author has succeeded in keeping the book to its original length.

Professor Simpson's " Forensic Medicine " is a book which every general practitioner and medical student should have at hand.

A. KEITH MANT.

TEXTBOOK OF OBSTETRICS

by J. F. Cunningham. 7th Ed. Heinemann, London. 1964. Pp. 562. *Price* 60/-.

This textbook on obstetrics, first published in 1951 by Professor John F. Cunningham, is now in its fourth edition. It is four hundred and ninety pages long and costs three pounds. It is a book written primarily for the student, but has the General Practitioner in mind.

It is claimed that this book is up to date, but several treatments advised appear out-dated. For instance: packing the uterus for severe bleeding following abortion or delivery is suggested; the use of oestrogens and the introduction of bougies to induce labour; one is told not to apply forceps until the patient has been two or three hours in the second stage! Many explanations and definitions in this book just fail to make their point. It would take a student of more than average intelligence to comprehend the difference between engagement and fixation of the foetal head. It would also take the same student a long time to decide his own management of a given case of post-partum haemorrhage. The chapter on operative obstetrics is well written and well illustrated. Even so, I do not think that this book represents value to the average undergraduate.

M. F. TERRY.

THE CARE OF THE INJURED.

by Paring, M.S., F.R.C.S. 1st Edition. Livingstone, London, 1964. Pp. 164. *Price* 25s.

This short book readily achieves its primary aim of being an introduction to accident surgery.

The book is chiefly directed at nurses and senior medical students but should be available for use in all Casualty departments. The first chapter adequately deals with the general care of the injured patient, and there are concise chapters on the response to injury and the management of open wounds. There are other chapters on head, chest and abdominal injuries which deal briefly with the principles of management of these conditions. The chapters on fractures and joint injuries are well written and briefly cover the subject—I am pleased to note that, in addition to short sections on peripheral nerve and tendon injuries, there is a final but most important chapter on the problems of rehabilitation.

The print and lay-out are good and the illustrations are clear. The majority of the X-ray prints are well produced. This book is short but covers all the main points in the management of the injured patient.

D. J. RICHARDS

A SYNOPSIS OF BIOLOGY.

by W. B. CROW. Wright's Synopsis Series. John Wright. 1964. Second Edition. Pp. 1,056. *Price* 52s 6d.

The first edition of this reference book was favourably reviewed in the *Gazette* (No. 1881, p. 321) four years ago, but it was then pointed out that the very high cost of the book (90s.) compared with others in Wright's Synopsis Series would almost certainly go against it.

It is pleasing therefore to report that by the simple expedient of virtually reprinting the book, with only minor alterations in the text, and by adding a list of addenda and corrigenda, the publishers have been able to reduce the price very considerably and, at 52s. 6d., it is now very good value for money.

As previously stated, this is essentially a quick-reference work for checking names, uses, facts, form and function of almost anything that can conceivably be regarded as biological. With 22,000 entries in the index, it ranges from the Aard-vark to Zymo-proteins, and the text covers not only the more obvious aspects of biology: morphology, physiology, ecology, genetics and evolution, but in the section on Applied Biology, topics include Food (Cannibalism to Ice-Cream), Drugs, the Biology of Gardening, Domestication of Animals, Fishing and Fisheries, Hunting and Hawking, Textiles and other plant and animal products, Veterinary and Public Health aspects of Biology, concluding with Perfumery and Cosmetics.

Dr. Crow has established a "Whitaker" in Biology!

E. W. BAXTER.

MEDICAL BACTERIOLOGY.

Whitby and Hynes, by Martin Hynes. Churchill. 8th Ed., 1964. Pp. 495. *Price* 40 shillings.

This well-known book is a concise, yet quite detailed account of bacteriology, and includes sections on mycology and parasitology. Numerous revisions and additions have been made in the text, including the chapter on antibiotics and chemotherapy, where a brief glossary of some of the individual drugs is given.

The medical student will find "Medical Bacteriology" a very useful and lucid book since emphasis has been laid on general principles of bacteriology and on the aspects of this subject which are important in the understanding and application of clinical and preventative medicine.

J. W. B. FRANKLIN.

Residents' Play

A record of the songs and music of this year's Residents' Play may be purchased as usual. The recording will be of a higher quality than usual, and is available at the reduced price of £1 1s. 0d. for a 12-inch long playing record. Please send applications to C. P. W. Warren or the President of the Residents, East Wing, Guy's Hospital.

SPORT

Guy's have suffered cruelly at the hands of Mary's this year. Hopes of collecting the Rugby and Soccer Cups were dashed when Mary's, in the past week, beat us in both competitions. After drawing 8—8 in the first match, Mary's scored in the dying minutes of the replay to win 8—3, in the Rugby Cup.

Guy's went on to the field in the first game very much the underdogs, and came off knowing that they were more than a match for Mary's, for it is very fair to say that Mary's scraped a draw. Guy's were leading 8—3 early in the second half and thereafter attacked the opponents' line unceasingly. Completely against the run of play, from a very unlikely position and aided by a fortunate bounce, Mary's scored ten minutes from the end, and survived to fight again. Guy's had a good reason to be confident of winning the replay, not only on the strength of this performance, for in the intervening week, Guy's had beaten London Irish 13—0, and Mary's had suffered a considerable defeat. Thus, with Guy's spirit rampant, one expected a fiery opening in the replay. This was not to be, for Mary's produced some fine rugby, completely dominating the first ten minutes and inevitably they scored a very good try. Guy's equalised with a penalty just before half-time, and were lucky not to be facing a considerable score, for the Guy's defence, on several occasions, was severely tested.

Guy's, possibly because of the poor performance in the first half, came to life now and the play was more equal, when the referee was severely injured! This was a critical time for Guy's, and to suggest that Guy's were any more upset by the subsequent hold-up than were Mary's would be stupid, but this and several farcical incidents, as when the new referee's whistle ceased to function, hardly helped a side which was just beginning to assert its superiority. Mary's scored a try about five minutes from time, and in spite of a period in which Guy's played like men possessed, and all but crossed the Mary's line, they had won.

In the Soccer Cup, Guy's were beaten 1—0 by Mary's, whom they had beaten 6—0 earlier in the season. To complete the tale of woe, Bart's, after two replays, beat Guy's 1—0 in the Hockey Cup.

Reports and Results

RUGBY FOOTBALL

Hospital Cup Semi-final

GUY'S v. ST. MARY'S

At Richmond. 16th February, 1965

Result: drew 8—8

Guy's won through to this semi-final with a comfortable win over Charing Cross. Only one victory had been recorded in the New Year, and even Rupert Cherry predicted a victory for the favourites, St. Mary's.

As has often happened in the past, Guy's began slowly, Mary's winning a large proportion of the ball in the early part of the first half. Bevan managed to work the touchline diligently with the small amount of ball he received, and this helped the pack to get on terms.

The lineout play improved considerably, although the loose scrummages were still being controlled by Mary's.

The midfield defence held the Mary's threequarters in check, and Allan especially brought off some fine first-time tackles.

Myall's chance to open the scoring failed with a penalty from the half-way line. After 20 minutes Mary's took the lead with a penalty for obstruction by a Guy's threequarter on their 25 yard line. Myall levelled the scores with a similar penalty after Allan had fiercely tackled his opposite number who failed to release the ball.

Guy's ended the first half pressing the Mary's line, and after half-time continued to do so. Winning more of the ball, Guy's still preferred to work the touchline until into Mary's "25". Mary's attempted to play more to their threequarters, and were forced into errors with good work by Baker, Sharp, and Allan.

The pack had the beating of St. Mary's with Hockey, Fisher, Kingdon and Cockburn well to the fore. At this stage Baker, the skipper, was injured, but played just as efficiently with a broken nose.

A short penalty was quickly taken by two over-anxious forwards, but not from the mark. Mistakes of this type can lose games!! From this scrum Guy's attempted to push over, and when held, Brown, picking up, forced his way over for their first try. Myall converted.

Back came the Guy's pack, and several opportunities to score went astray. An attempted drop goal by Bevan became a beautiful cross-kick, and Kerner, following up fast, misjudged the bounce with a clear line.

Five minutes from time, encamped in the Mary's "25", possibly bad play by Guy's, but more likely good play by the Mary's fly-half, gave them the equalising score. Winning a lineout 15 yards from their own line, a huge downfield kick by Thomas caught Guy's defence unprepared. The bounce was unkind for Guy's, and the winger, given an inside pass, touched down between the posts untouched for a converted try.

This was a game that the Hospital should have won comfortably. The Mary's team were made to look rather ordinary, but still showed touches which could lead to scoring chances. Guy's had these chances, and failed to take them.

Tuesday, 23rd February, 1965

Semi-final Replay

Result: lost 3—8

A 13—0 victory on the Saturday over London Irish increased our hopes for this replay. Unfortunately, we were matched against a completely different side. Guy's attempted to play the same type of game as last week, and did so less efficiently. Mary's, in all phases of the game, adopted new and superior tactics. Mary's lineout play improved on last week's performance in that they attempted, and succeeded, in the unorthodox method of tapping back. Their loose scrummaging improved on the previous game; only one loose heel being recorded by Guy's throughout the whole game. They also won slightly more of the set scrummages. With this service from his pack, Wintle set about to defeat Guy's. He kicked well to touch, tested mid-field defence with high punts, and broke cleverly, joining up with his back row.

Mary's began with urgency, and scored after ten minutes, before Guy's had settled down. Mary's won a lineout,; their fly-half kicked over the lineout. The yellow stripes of Guy's could scarcely be seen in defence, and Edgar and Myall were beaten to the touch down. The conversion failed.

Mary's continued to press, but failed to press home their advantage. Following a beautiful run by Ross, for Guy's, from 25—25, Brown backing up well, received a rib injury and left the field. He returned to play no further part in the game. A two-man back row was the last thing Guy's needed in this type of game.

The score at half-time flattered Guy's, as, on half-time, Myall, using his experience, fielded, ran, and cross-kicked. He kicked the resulting penalty for offside from 25 yards.

After half-time the Guy's forward play improved, and this, and good runs by Ross, brought Guy's into the Mary's half. The most important incident in the whole game, as far as the minor press were concerned, was an injury to the referee. While a new one was found, Guy's lost their hard worked for advantage, and Mary's again took control. They scored a try through Wintle with a blind-side break, and were unlucky not to score one or two more.

Mary's continued to press until the last 10 minutes. Guy's attacked through their three-quarters without real purpose and failed to produce a score.

The 8—3 final score did not reflect Mary's superiority.

Both games proved excellent Cup matches. It is difficult to compare the two games. The first belonged to Guy's, and produced a draw. The second to Mary's, giving them a place in the final yet again.

GUY'S v. LONDON IRISH

At H.O.P. 20th February, 1965

Result: won 13—0

A considerable layer of snow and a cold easterly wind made conditions unfavourable for good rugby. In fact, at the beginning of the match more greenery was apparent from the collected shirts of the visitors than from the pitch, although all the lines had been well cleared. Within these circumstances, the Hospital more sensibly adapted themselves and their tactics, than did the opposition, and came out certain victors by two goals and a try to nil.

The Irish, including international centre Houston, won the toss and elected to play with the strong wind at their backs. For most of the first half their large forwards gained considerable possession from line-out and scrum. Strangely, they ignored their advantage of a following wind, and in spite of numbed hands and difficult running conditions, they persisted to attempt to pass the ball down the lines. Making up for their lack of possession, Guy's were able to pounce on the many Irish mistakes incurred by the latter's attempts at open play. From a penalty, awarded inside the Irish half, Edgar, followed up Myall's unsuccessful kick at goal, and gathering the ball just short of the goal-line, dived over amidst the seemingly paralysed Irishmen. Myall appreciated his second chance, and the Hospital changed over five points up.

Again in the second half Guy's had limited possession. But, with whatsoever ball was obtained, full use was made of the wind to remain in the Irish half. The Irish were already a little dispirited, and became even more so when Ross was given the ball, and, beating several coverers, went over in the corner. Myall converted magnificently from the touchline. There was now no let-up, and testing kicks by Bevan and Rowlands kept the opposition in their "25". A desperate clearing kick by the Irish scrum-half, under his posts, failed to find touch, and Ross, seizing his chance, made straight for the corner—Myall's kick failed.

The rugby was limited in variety, but in difficult conditions the Hospital gave more experienced opponents a lesson in calculated tactics and taking chances

Team: R. W. T. Myall; R. Kerner, J. A. Edgar (Capt.), A. J. Allan; J. Ross, B. Rowlands; D. R. Bevan, J. E. Davies, P. Ashcroft, A. Fisher, M. Cockburn, A. J. Kingdon, H. Sharp, K. Brown, P. Williams.

HOCKEY

Hospitals Cup 2nd Round, 2nd Replay

GUY'S v. BART'S

At the London Hospital Ground.

17th February, 1965

Result: lost 0—1

Of three tough games this was, perhaps, the least memorable; but when two average sides have twice within a fortnight fought out a goal-less draw one cannot expect a good game of hockey.

Guy's started well with a number of well directed attacks that looked full of promise. However, within a quarter of an hour, with only their second attack, Bart's had gone ahead. The ball was centred from the left, and a large gap in the left of Guy's defence left the inside right with plenty of time to place an unstoppable shot. The rest of the half was rather indeterminate for the large amount of hard work put in. Bennett, in particular, had a fine game, showing more punch and thought than most.

The second half was virtually all Guy's, with very few Bart's attacks—but their defence never looked seriously in trouble. Hirst, in Guy's goal, touched the ball less than half a dozen times, but the Bart's 'keeper was no more busy. As usual (how often this has been said!), Guy's did not use their wings nearly enough to split the opponents' defence; but no winger will see much of the ball if he does not make serious efforts to get it, rather than just waiting. Bart's goal was not entirely free of luck, for a reverse stick effort by Appleby was only inches wide; but in general there was little danger from the numerous Guy's efforts that the packed Bart's defence could not deal with.

Basically Bart's scored one good goal and so go into the semi-final, mainly because their

defence conceded no goals in 4 hours 10 minutes. However, if Guy's had taken their half-chances, as they did to win the Cup last year, any one of these three games could have been won.

Though naturally very disappointed, the team's congratulations and best wishes go to Bart's. For the first time for many years the Cup will not go to one of the "big three" hockey hospitals—perhaps a good thing as far as hospital hockey is concerned. However, it was good to hear the umpire saying the final would be a poorer game now that Guy's were out of the Cup.

KEITH HAYNES

Team: A. Hirst; D. Loader, K. Haynes; J. Crafts, C. Brooks, P. Rushmer; R. Carruthers, S. Cripps, M. Appleby, P. Bennett, A. Winskill.

BOXING

GUY'S v. LYNN CLUB

At Manor Place Baths. 8th February, 1965

Result: lost 2—3

This was a fixture involving a new trophy, kindly suggested and subscribed to by Mr. W. Sheeran. Hospital supporters were not overwhelming, but the few present were much appreciated.

The first bout, for the Matt Wells trophy, was between W. Onyeama (Guy's) and "Tiger" Jones. It soon became obvious that Onyeama was scoring effectively with his left and gaining confidence. Onyeama attacked with exuberance, forcing Jones to the ropes, and the referee to stop the contest.

The next match was made between T. Gibson (Guy's) and B. Richardson. From the start it was evident that Gibson was unaccustomed to his adversary's south-paw style. Although faster on his feet, the Hospital boxer was unable to match his left with his opponent's right. Settling somewhat in the last two rounds, Gibson was able to land some solid rights, and succeeded in avoiding much in-fighting. Nevertheless, it was Richardson's bout plainly, but not easily.

In the third contest D. Edgar (Guy's) met S. Reid. Edgar fought what was for him an *unusual defensive position. Reid spent much* time slapping wildly, but with alarming stamina. Edgar's fatigue became more obvious, and Reid pressed harder, but unsucessfully, to knock him down. Reid won, but probably only because of his obvious last minute advantage.

The fourth bout was between K. Hughes (Guy's) and R. Sully. The Lynn boxer looked more solid and took the initiative, but Hughes scored accurately with both hands Unhappily, Sully was unshaken, and put down Hughes for a leisurely count of nine. Hughes absorbed most punishment on arms and gloves, but once again lack of fitness was the undoing of a Guy's boxer. However, at the final bell he was still fighting back.

The last, and most entertaining, contest was between E. Chater (Guy's) and J. Elroy. Chater commenced by retreating insolently from a determined attack, and the crowd appreciated both skill and sang-froid. From time to time the Guy's boxer indulged in a certain amount of back-chat with his delighted audience. His unfortunate opponent was out-manoeuvred by a bewildering stratagem, disconcerting laughter, and the intermittent barking from his canine supporter. This was a clear victory for Guy's.

The Hospital failed to gain the trophy, but provided no lack of entertainment in an evening of good sport.

A. CRAIG

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Locum Middle-Grade Registrar in the Department of Anaesthetics** for the period 10th May to the 30th September, 1965. Application forms are obtainable from, and should be returned to, the Superintendent, Guy's Hospital, S.E.1, not later than **16th March, 1965.**

HOUSE APPOINTMENTS

GUY'S HOSPITAL

March 1st, 1965

Assistant House Surgeons

To:

Mr. Lawrie — Mr. G. Hambleton
Appointed for 6 months, the first 3 as A.H.S.

Mr. Glover — Mr. I. A. Baker
Appointed for 6 months, the first 3 as A.H.S.

Mr. Brain — Mr. R. A. Y. Pietroni
Appointed for 6 months, the first 3 as A.H.S.

Mr. Beard — Mr. A. L. W. F. Eddleston
Appointed for 6 months, the first 3 as A.H.S.

Assistant House Physicians

To:

Dr. Mann, Dr. Scott and Dr. Bishop — Mr. M. W. J. Older
Appointed for 6 months, the first 3 as A.H.P.

Dr. Hardwick, Dr. Trounce and Dr. Deuchar — Mr. I. C. M. MacLennan
3 *months*

Dr. Baker, Dr. Houston and Dr. Grimble — Mr. H. D. Tunstall Pedoe
3 *months*

Dr. Kauntze and Dr. Joiner — Mr. P. C. Smith
Appointed for 6 months, the first 3 as A.H.P.

Professor Butterfield and Dr. MacLean — Mr. T. M. Jenkinson
Appointed for 6 months, the first 3 as A.H.P.

Casualty Officers

Mr. T. C. Davis
Mr. T. F. W. Dilke
Mr. R. Gilkes
Miss C. G. Gladstone
Mr. A. J. Knell
Mr. M. Wastie
} 3 *months*

House Surgeons

To:

Mr. Eckhoff — Mr. A. Dowlatdad
3 *months*

Professor Atkins — Mr. J. R. W. Keates
6 *months*

Mr. Wass — Mr. P. Banks
3 *months*

Mr. Blackburn — Mr. T. J. B. Harris
6 *months*

House Physicians

To:

Dr. Mann, Dr. Scott and Dr. Bishop — Mr. P. K. D. Bush
3 *months*

Dr. Hardwick, Dr. Trounce and Dr. Deuchar — Mrs. J. E. Husband
3 *months*

Dr. Baker, Dr. Houston and Dr. Grimble — Mr. F. D. Higgs
6 *months*

Dr. Kauntze and Dr. Joiner — Mr. C. P. W. Warren
6 *months*

Professor Butterfield and Dr. MacLean — Mr. B. G. R. Neville
3 *months*

Resident Obstetricians
1.11.64—30.4.65 Mr. J. R. Hockey
1. 3.65—31.8.65 Mr. E. E. Cockayne

Throat and Ear House Surgeons
Mr. D. G. Nancekievill — 3 *months*
Mr. T. E. J. Healy — 6 *months*

Orthopaedic House Surgeons
Mr. R. L. Strickland — 3 *months*
Miss S. H. Marshall — 3 *months*

Dermatological House Physician
Mr. P. C. H. Newbold — 6 *months*

Neurological House Physician
Mr.. I. Vadasz — 6 *months*

Genito-Urinary House Surgeon
Mr. N. Ramsbottom — 3 *months*

House Surgeons to the Thoracic Unit.
Mr. D. K. C. Cooper — 3 *months*
Mr. S. Nundy (S.H.O.) — 6 *months*

Children's House Physicians
Mr. R. Jacques Parker — 3 *months*
Mr. C. J. Atkins — 6 *months*

House Physicians in Clinical Pathology
Mr. M. D. Jones — 3 *months*
Mr. P. Sender — 6 *months*

House Physician to Dr. Bishop, Dr. Wayte and Mr. McArthur.
Mr. R. A. Sturge — 6 *months*

Gynaecological House Surgeon
Mr. P. J. Rowe — 6 *months*

House Physicians in the Department of Psychological Medicine
1.4.65—30.9.65
Dr. Stafford Clark — Miss M. Restell
1.4.65—30.9.65
Dr. Fleminger — Mr. R. H. S. Mindham

R.M.O.s in Nuffield House
1.1.65—30.6.65 Mr. I. M. Boyd
1.3.65—31.8.65 Mr. J. D. Jessop

Resident Anaesthetists
1.12.64—31.5.65 Miss M. J. Wallace (S.H.O.)
1.12.64—31.5.65 Mr. M. J. Wright
1. 3.65—31.8.65 Miss D. Hart (S.H.O.)
1. 3.65—31.8.65 Mr. R. K. R. Innes

HITHER GREEN HOSPITAL
House Physician in General Medicine and Infectious Diseases:
Readvertised

JOYCE GREEN HOSPITAL
House Physician:
Appointment made by Hospital
House Surgeon: Readvertised

LEWISHAM HOSPITAL
House Surgeon to Mr. Cavendish:
Mr. H. Munitz
House Surgeon to Mr. Le Brun:
Mr. D. J. O'Gorman

NEW CROSS HOSPITAL
Senior House Officer in Medicine and Geriatrics:
Mr. M. N. Maisey

ORPINGTON HOSPITAL
House Physician:
Appointment made by Hospital
House Surgeon with Orthopaedics:
Mr. A. J. Hazzard
House Surgeon with Physical Medicine:
Appointment made by Hospital

QUEEN MARY'S HOSPITAL, SIDCUP
House Surgeon: Readvertised
House Physician: Readvertised

ST. JOHN'S HOSPITAL, LEWISHAM
Casualty Officer and Orthopaedic House Surgeon:
Readvertised

PASS LISTS

ROYAL COLLEGE OF SURGEONS OF ENGLAND

Final L.D.S.

Part 1. Surgery
R. H. G. Archer — R. E. Knight
Primrose A. Hubbard — D. C. E. Loader
Dianne B. Morgan

Part 2. Dental Surgery
J. W. Balchin — C. B. Hone
D. J. C. Barnes — J. R. P. F. Liddiard
C. J. G. Coe — W. Martyn
R. F. Davey — R. Morris
Helen M. Gray — J. V. B. Robinson
Priscilla M. Heather — E. Tiller
C. J. S. Wright

NURSING NEWS

Left
Sister M. Walker from Addison Ward.
Staff Nurse S. Fowler from Addison Ward.

Entered
Charge Midwife J. Ashton to Victoria Ward.
Staff Midwife L. Bolt to Victoria Ward.

PERSONAL

A Jumble Sale is being held in the Nuffield Nurses' Home, on Friday, 26th March, 1965, at 12.30 p.m.

If you have any articles suitable for disposal on this occasion, we would be very grateful if you would kindly send them, or leave them at 24, St. Thomas' Street, on Tuesdays and Thursdays, or the Superintendent's House on any other day of the week.

Mrs. Warner is holding a Raffle, and she would be very glad of offers to sell tickets. Would anyone wishing to do so please write to Mrs. Warner, 65, Melton Court, London, S.W.7.

If you want to practise Medicine as a way of life, my partner and I offer you short assistantship and a very early partnership in modern practice with two surgeries fully equipped. Great scope in parish for growth. G.P. Hospital, possible hospital appointments, close connection with teaching hospital, midwifery.

We cannot offer the usual fortune for the first two years but if you are the right doctor you will earn about £4,000 within three years. Starting salary for assistant, £1,850 per annum to £2,000 per annum after three months.

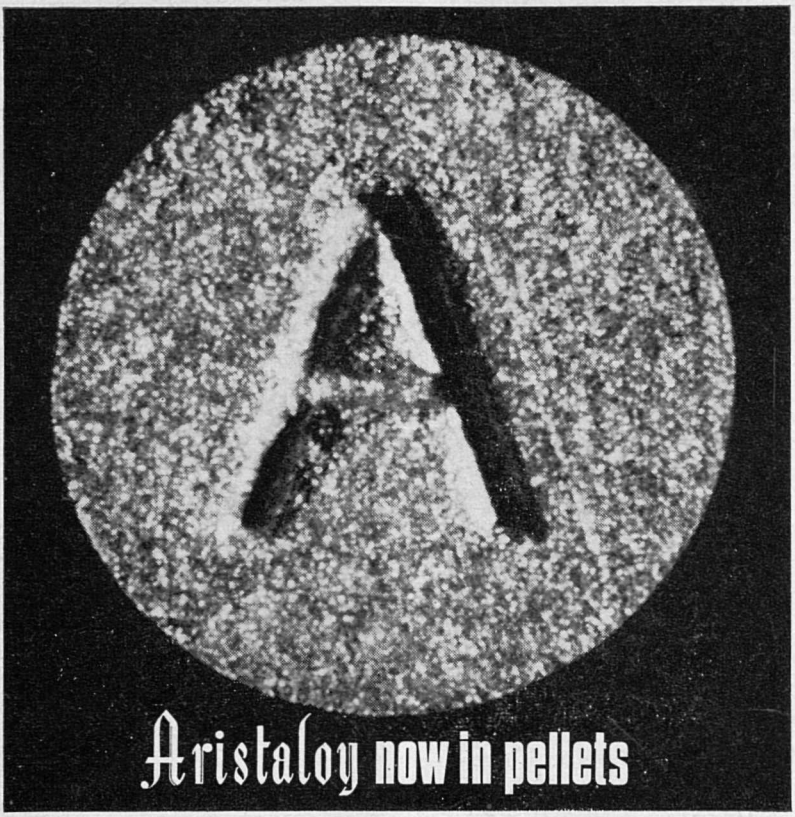
Would like to try you out, if possible as a locum, and you us. A flat or house available. No snags. Reply: Dr. K. I. Porges, 170, South Norwood Hill, S.E.25.

S.O.S. Wanted, a State Registered Nurse to take charge of a Home for 6—12 unmarried Mothers and Babies in Kilburn. Suitable appointment for a widow or one seeking a permanent resident post. For further details apply to: Matron, Guy's Hospital.

AUSTIN MINI (1960), grey. 39,000 miles. Very good condition. Heater, wing mirrors, new battery, £230 o.n.o. Box No. 1.

BIRTH

PRITCHARD.—On 26th January, 1965, in British Military Hospital, Benghayi, to Carole (née Wigg) and Major Henry Pritchard, B.D.S., R.A.D.C., a son, Jonathan Henry Charles, a brother for Mark.



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GUY'S HOSPITAL GAZETTE

FORTNIGHTLY ONE SHILLING VOLUME 79 NUMBER 2000

20 MARCH 1965

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EDITORS B. H. HICKS AND P. BOWDEN

SPORTS CORRESPONDENT A. PROCTER

GUY'S HOSPITAL, LONDON

Gazette 2000

Like some blushing maiden, shyly conscious of her ninety-three years, the *Gazette* now dares to look upon itself as in a mirror, examine its wrinkles, exclaim at its spread and think towards the future and its prospects. Yet many at Guy's have perhaps thought little enough of the present, and presence, of the *Gazette* before we prematurely dash ahead.

The present "function" of the *Gazette* would be difficult to define. Its origins as a journal were essentially as a newspaper, written strictly *by* students *for* students, to report events and lectures in the hospital. With the passing of years the content has evolved to the point where the range of interest, the term of reference if you like, has broadened immensely. A number of factors have contributed to this flowering, and it would be difficult to select any one or two as primary influences. The "news" and "notice" value is much augmented by the issue being fortnightly (a frequency unrivalled by other journals of a similar nature). The "feature" content is enriched by the range of subjects that can be classified as pertaining to medicine, to dentistry, or to Guy's. The journal as living journalism is given body by its wide subscription list, itself a reflection mainly—we think—of the *corps d'esprit* of our Hospital. Finally, it *should* be sustained by the interest of those who gave it existence, the Guy's men and women who are still studying.

Tragically, we have to say "should be" rather than "is", for at the present time, were the *Gazette* dependent on the student interest for its survival then survive it certainly would not. This is not a new complaint, echoed as it is in the *Gazette* of 1874, and in many student journals of 1965, but must it go unheeded? The *Gazette* is a free and independent journal, its columns are given primarily to student voices (when they can be heard), and it is theirs by inheritance. One should not need to tell students of a University that in a subject which they have studied with care, they may instruct not only their colleagues, but also their seniors. After generations of Guy's students have kept the *Gazette* strong and known, this generation should not lightly cast it aside. Compared with other hospital journals, considering its frequency, the *Gazette* is well-provided with copy; but from students, nil. Full articles contributed by students in the last twelve months : six. The expert opinion, the qualified account, is a necessary and desirable balance; but it must balance something, something which only the student can provide.

For the future, the prospects are mixed. In terms of readership and interest, one may justifiably hope for further progress to be made and further achievements to be charted. Economically, the storm clouds are still overhead. The costs are still rising sharply, and the magazine is still being published on a shoestring. When the *Gazette Committee* are counting their small change it may not be too soon to

remind Guy's men of simple things, of the origin and tradition of their *Gazette*, of its place in the Hospital function and spirit, and of its need for them. If, eventually, the subscription must rise, we hope that they will measure their loss against Guy's gain. When men qualify and leave, we hope they maintain their interest by spending a few pence a week. The *Gazette* is a faithful servant of Guy's that asks only for its means of subsistence.

Finals

Lacking confidence, feeling apprehensive or frankly having not done enough work opens the candidate to the rituals of compulsive myth. The last few weeks are plagued with counting pennies, crows in trees and even cigarette butts in unknown ashtrays. It's odds for a pass and evens fail. Why can't it be vice versa?. It may just as well be dup-lub, it's equally logical. The last journey is terrible. If the Tube door shuts before twenty's counted, pass. One, two, three . . . please close . . . sixteen, something has happened to the train, count slower . . . perhaps the guard has had a coronary. What's the treatment for coronary thrombosis? Eighteen, nineteen . . . weren't thirteen and fourteen missed out? Recount. No. that's cheating. Twen . . . they must close . . . twent . . . they are, they're shut. Twenty.

On to Examination Hall, count the paces from the telephone kiosk to . . . no, it's stupid. Then come the puny jokes and the endless waiting. If the person before me fails, I pass, this is final and cancels everything else. He failed, great. Candidate 200 . . . Yes . . . Mr. Washington . . . Yes . . . You failed to satisfy . . . Damn. It was because I counted twenty too slowly, that's why I failed, I cheated.

We neglected in earlier *Gazettes* to acknowledge the conferment of the readership in experimental neuroanatomy on Dr. P. L. Williams, in respect of the post held by him from October, 1964. He is working on the microstructure of nervous tissue.

We look forward in the coming week to some savoury items among the more basic fare of clinical lectures, a series of distinguished guest speakers on the "History of Medicine". Dr. Calvin Wells, author of the book "Bodies, Bones and Disease", has previously delighted Guy's audiences. Sir Ian Richmond is both excavator and writer, author of the "Pelican" on "Roman Britain", and an authority on his subject. Professor Schadelwaldt is rumoured to be bringing some original recordings of primitive music used for therapy, as well as ideas on the "dancing mania" of the Middle Ages and on the evolution of some modern dances. Dr. Clarke, of the Wellcome Institute, is taking the broader view of historical concepts of disease. The roll of honour bodes well for a fascinating week.

Ninety pounds a week, a five-and-a-half day working week, overtime pay for week-end and night calls, status *and* six weeks' holiday a year! Just who do they think they are—the Minister of Health?

The series of articles, "Thoughts on Education", will be concluded in the next issue of the *Gazette*, and we hope that we may before then hear some student opinion on the views expressed (there having been none to date). We apologise to this week's correspondents for the delay in publishing their letters, which will also appear in the next issue, owing to pressure of space in this special edition.

The same pressure has squeezed "Sport" out for this one issue. Patience, fortunately for Editors, is a virtue.

Spanish Students

The syndicate system in Spain is one of the pillars of the Fascist government. It pervades every aspect of life from state-controlled worker and employer associations to the Cindicato Espanol Universitario, the State-controlled Student Union. In Barcelona, Seville, Oviado and Madrid students have asserted their right to be free, two were shot and many imprisoned. In Europe, student bodies are an important force of political power and persuasion as well as an outlet for public opinion. They must be autonomous or the very essence of their existence is challenged. The anonymity of our British Student Unions may be explained, in part, by their lack of purpose and function beyond social spheres. It is the recurring theme of abuse of privilege.

GUY'S DIARY

MARCH.

EXHIBITION.		*Catheterisation.*
		" HISTORY OF MEDICINE"
22nd M.	1.00	Dr. CALVIN WELLS, Ph.D., M.R.C.S. Lecturer in Dept. of Ethnology, Cambridge University. *Diseases of the Anglo-Saxons.*
23rd T.	1.00	Professor Sir IAN RICHMOND, O.B.E., LI.D. Fellow of All Souls College, Oxford and Professor of Archaeology of the Roman Empire, Oxford University. *Roman Military Hospitals.*
25th Th.	1.00	Dr. E. S. CLARK, M.D., M.R.C.P., of the Wellcome Institute, London. *The History of Disease and Asepsis.*
26th F.	1.00	Professor W. SCHADELWALDT, M.D., Professor of the History of Medicine in the Medical Academy, Dusseldorf. *Music and Medicine.*
29th M.	1.00	Dr. E. J. MOYNAHAN. *The History of Smallpox Inoculation and Vaccination.*
30th Th.	1.00	Dr. JOINER. Clinical Lecture.
APRIL.		
1st Th.	1.00	Dr. A. J. ROSIN. *Diagnostic Difficulties in the Elderly.*
2nd F.	1.00	Dr. A. J. ROSIN. *Aspects of Disease in Old Age.*

The 2,000th Gazette of The New Series

A Short Resumé of the Gazette's History

The *Guy's Hospital Gazette* can properly claim to be the oldest surviving students' journal in the world. When it appeared in 1872 there was already in existence a monthly magazine known as the *London Students' Gazette*, which had been started in March 1871, but this journal ceased publication many years ago. The next students' journal to appear (and survive) was that of *St. Thomas's*, some eighteen years later.

1 Oct., 1872 The *Gazette* was founded as a private venture selling at 2d. a weekly copy by T. Cattell-Jones, a second-year student. He was assisted by Henry Clarke, a dental student, and Edward Giblin. From the second number onwards it managed 8 pages to an issue, and its reception from both staff and students was enthusiastic. The objects were pointed out in the opening paragraphs: *In launching this little sheet . . . we . . . wish to draw the attention of Guy's men to what our present intentions are. . . There has been a great want of communication between one class of Guy's men and another. . . It is . . . our intent to bring before students an account of everything of interest that passes at Guy's, so that he may, as it were, have his powers of observation multiplied.*

19 July, 1873 Cattell-Jones qualified and relinquished his post, and the *Gazette* was managed for the ensuing two months by Giblin and Clarke, until Frank Paul replaced Clarke.

11 Apr., 1874 John Utting was co-opted onto the staff. These three worked under increasing pressure to produce the weekly *Gazette*, until their studies forced them to make an announcement in the issue of . . .

30 May, 1874 *In earnest desire to increase the value of our* Gazette, *it has been realised that the Editorship should no longer rest in the hands of one person, but that the duties and responsibilities, which of late have considerably increased, should be shared by a small staff of students. . .* The new structure was hardly a success, although the fault did not lie entirely with the *Gazette*, as became clear in the published decision not to print weekly during the summer vacation. . .

25 July, 1874 *This Gazette will not appear every week during the vacation; it will be published and sent to subscribers as matters of interest require. . . We have no wish to conceal the reason for this spasmodic issue. It is due to the lukewarm support of the students and to the backwardness of some of our country subscribers. . .* Sentiments that could fairly be echoed by the present *Gazette*!

26 Sept., 1874 The proprietorship of the *Gazette* had passed from Cattell-Jones to Orlando Gibbs Brimmer, the printer, of 104, Borough High Street. The announcement now appeared: *On the 1st October the* Guy's Hospital Gazette *will appear under new management. Mr. Brimmer . . . has made over his interests in the paper to the Presidents of the Physical Society, by whom in future it will be conducted.* The Editors explained that: *The superintendence of the* Gazette *was, greatly to its detriment, frequently changing hands, and the practical difficulty of continuing a journal brought out by students, whose term at the hospital was necessarily so uncertain, has at length become insuperable. If the* Gazette *is to be continued at all it will clearly better be carried on to better advantage by a perpetual society than by one or more ever-changing individuals.* One other important change at this time was the appointment of a business manager, Mr. M. H. Williams, the Hospital accountant.

13 Nov., 1875 The printing passed into the hands of W. Drewett, of 43, Borough High Street, with a resultant increase in quality of production, and the price was increased to 3d. a copy.

18 Dec., 1875 This was the last of the weekly *Gazettes*. Henceforth the *Gazette* was published at fortnightly intervals, as it has been, with rare exceptions (e.g. the one issue missed during the General Strike), to the present day.

10 July, 1880 With the backing of the Physical Society and a succession of able Editors, the *Gazette* flourished; until, in 1880, there came a visitation from The Gods. C. H. Downes wrote an outspoken editorial about the pay dispute then in progress between the Governors and the Nursing Staff—siding firmly with the Nurses. The Governors perhaps thought this gave them an unfair advantage, but for whatever reason the axe fell swiftly. The *Gazette* was banned, and for six and a half years did not appear.

1880—1886 Towards the end of this period the idea of re-establishing the *Gazette* became more popular until, in November 1886, the Governors gave their permission, provided that a member of the Staff acted as censor.

No. 1
8 Jan., 1887 The first of the New Series was published by the Physical Society, the President of which acted as Editor. The printers were Ash and Co., 42, Southwark Street. *Passim* made its first appearance (*and is still going strong . . . Ed.*).

No. 22
26 Nov., 1887 The *Gazette* was now issued in a wrapper and had reached a circulation of nearly 400. The average number of pages had reached fourteen.

No. 23
10 Dec., 1887 The Gazette printed its first illustration, that of a lamp invented by Mr. George Carpenter for use in laryngoscopic and ophthalmoscopic work.

No. 24
24 Dec., 1887 The Committee system in operation for the first year of the New Series was clearly impracticable, and in this issue the Editor dealt with it at some length, ending: *So much for the Committee system. It has been imperceptibly replaced by a far better one, the now pretty generally recognised conception that all Guy's men, past and present, are—or rather should be—ipso facto members of our staff and possible contributors to our columns.*

5 Jan., 1889 In an attempt to increase circulation, 2,500 copies were printed and sent to all Guy's men. The subscription for the *Gazette* was now 7s. 6d. a year, post free.

29 Mar., 1890 This was a special double number of twenty-four pages, on the occasion of the opening of the new Students' College by Mr. Gladstone, then a Governor of the Hospital. Of particular historical interest was his description: *". . . a convenient and highly creditable building of which London and this neighbourhood has no reason whatever to be ashamed"*. Had someone complained already? 20,000 copies of this Gazette were published at 6d. a copy to everybody, including subscribers.

5 Nov., 1892 Many numbers of the *Gazette* now contained twenty-four pages, and in the following year an average of thirty-two pages per issue was achieved.

23 Oct., 1897 The *Gazette* Committee was completely reconstituted. It was to consist of the Editor, the Manager, two members of Staff, two members selected by the Clubs' Union Council, the President of the Residents, and between four and six members co-opted by the Committee. In January 1900, the Treasurer was asked to relieve the Physical Society of all control, responsibility and ownership, nominal or otherwise, of the *Gazette*. Since that date the Gazette has been published by its Committee, quite independent of other societies and sections at Guy's.

Jan., 1904 *Passim* was moved to the front page, where it has remained ever since, and a slight change in the leader page put into effect. The circulation now exceeds one thousand.

1914—1918 During the war period the fortnightly issue was maintained, usually with the minimum number of 20 pages. In 1918, a special War Memorial edition was printed.

No. 884
21 Feb., 1920 The new post of Assistant Editor was instituted, in order that the Editor of the Gazette would always be experienced in its running on taking up the post.

No. 951
20 Dec., 1924

The circulation had now risen to 2,400, and was still rising. The price per copy was 9d.

No. 952
6 Jan., 1925

The Bicentenary of the Hospital, and the Centenary of the Medical School, were celebrated with a lavishly-produced edition of 216 pages, containing many accounts of Guy's and its institutions, past and present, under the editorship of Leslie George Housden.

No. 1003
1 Jan., 1927

About this time the *Gazette* was for the first time graced by a printed cover, its circulation now in the region of 2,700.

No. 1185
23 Dec., 1933

After years of financial security, the Gazette was suddenly faced with one of its gravest crises, when the Manager defected and it was realised that much of the credit balance was fictitious, and there was in fact a considerable deficit. However, the *Gazette* survived and paid off the deficit without borrowing or realising any capital, while the future was secured by the election of Miss Sidney as manager (a post she filled until 1961), and the appointment of official auditors to the Committee.

No. 1263
19 Dec., 1936

The *Gazette* proudly celebrated its 50th anniversary with a special Jubilee number of some 90 pages. The format was still 7½in. by 10in., that of Volume One of the New Series.

No. 1408
11 July, 1942

Shortage of paper compelled the Committee to reduce the page size of the Gazette to 5½in. by 8½in., or approximately its present size. The size and shape, besides giving a certain distinction to the Guy's journal, are still ideal for the large amount of mailing to which it is subject.

No. 1647
1 Sept., 1951

Rising costs led to the price per single copy of the *Gazette* being raised to its present level of One Shilling. The circulation at this date was 4,450.

No. 1949
6 April, 1963

This issue was the first in which advertisements were removed from the front cover, and the statue of Thomas Guy made its debut. In June 1963, the *Gazette* had a circulation of some 5,300, distributed approximately thus:

Posted inland	3,500
Posted abroad	500
Library copies (Students') ..	850
Hospital copies	450

No. 2000
20 Mar., 1965

The present circulation of the *Gazette* is still in the region of 5,300 copies, despite a slight loss in readership at the time of the subscription increase. In the face of ever-increasing costs, it is to be hoped the *Gazette* will maintain its fine reputation as the only students' or hospital journal published so frequently, for so long.

BRENDAN H. HICKS.

THE NEW GUY'S

A. H. BURFOOT

CLERK TO THE GOVERNORS

When Her Majesty Queen Elizabeth the Queen Mother unveiled the commemorative stone in the Colonnade on 16th December, 1964, her visit marked the completion of the restoration of Guy's House and the rebuilding of the East Wing in the front courtyard. The restoration has revealed a graceful simplicity in the two quadrangles which three years ago few of us knew lay behind the clutter of pipes and protuberances. The cleaned Portland stone of the front portico, still showing the signs of time, is best seen at night when floodlight gives it the unreality of a stage backcloth. Within these restored buildings Guy's has gained accommodation for its nursing and medical staff which sets a new standard of amenity. Colour schemes, furniture and furnishings all speak for the skill of Lady Boland, adviser on interior decoration. Carpeted corridors, pastel walls, pin-up boards in nurses' rooms, kitchenettes in sisters' flatlets are features of the new "background to living" for some 120 sisters and nurses and nearly 60 house officers. Even Passim in its second thoughts has admitted that the Clubs' Union accommodation in the East Wing is probably unequalled in London. While regard has properly been paid to physical comfort for resident staff, new offices provide greatly improved working conditions for many of our long-suffering clerical staff who have survived both the cramped confinement of the immediate post-war years and exposure to the elements during their stay in the temporary huts. A sandwich bar for non-resident staff has been constructed in the lower ground floor, and the Guild of Ex-Patients and Friends of Guy's Hospital has given most generous assistance in furnishing amenity rooms for nursing and other staff. For the Governors there is a new Court room to replace the lofty elegance of the early 18th century Court and committee rooms destroyed when the east wing was burnt out during the war. The new room was designed by Mr. Alexander Gray, the Hospital's Architect, and panelled by craftsmen in Douglas fir. A feature is the coat-of-arms of the Hospital carved in lime wood and presented by the Nurses' League in memory of Lord Cunliffe, the late Chairman. Other gifts were made by the Hospital's professional advisers. A very fine clock was presented by the Quantity Surveyors, Messrs. Eric G. Lynde and Partners; a set of blotters by Messrs. W. H. Watkins, Gray and Partners who took over as Architects for the scheme when Mr. Maurice Bebb, the original Architect, died so prematurely in February 1964; and a calendar, pen tray and blotter for the Chairman's place from the Consulting Engineers, Messrs. Brian Colquhoun and Partners. At their first full meeting in the new room in December last the Governors recorded their thanks to the Dean and Governors of the Medical School who had let them meet in the School since the destruction

of the east wing. They also decided that the date of the meeting and the unique record of its Chairman, Mr. E. G. Slesinger, should be inscribed on one of the panels. Mr. Slesinger was then in his 60th year at Guy's. He came as a Medical Student in 1905 and during his long career became Senior Surgeon and held office as Chairman both of the School Council and of the Medical Committee as well as being a Governor, Vice-Chairman and currently Chairman of the Board.

By February of this year the final account had been agreed with the contractors, Messrs. Y. J. Lovell (London) Ltd. It is worth recording that this scheme, which is probably one of the most considerable restorations of an early eighteenth century building undertaken for many years, has cost less than the contract sum. In total just over £1,000,000 had to be found. More than half of it was met by the Governors from their Endowment Fund. This represented the cost of reconstructing Thomas Guy's original building. Some £220,000 was provided by the University Grants Committee for the student accommodation and the balance of approximately £195,000 was paid by the Ministry of Health for house officer accommodation. The cost of the overall scheme was £6,000 less than the sum allowed.

This is a satisfactory outcome to a great undertaking. The alternative to restoration would have been total demolition. The vision of Sir Rowan Boland and others who led the move for restoration has been amply proved.

In 1957, when Mr. B. Lees Read, who was then Clerk to the Governors, described the events leading up to the commencement of work on New Guy's House, he recalled the fire raid in London on 29th December, 1940, which burnt out the majority of the warehouses and hop showrooms covering the site now occupied by New Guy's House and the public car park. He wrote of the morning early in January 1941, when the Treasurer at that time, Mr. John E. Humphery, and he walked around St. Thomas's Street, Weston Street and Snowsfields to see the ruin which the raid had brought to this area. Many of the warehouses and showrooms belonged to the Hospital and their rents had helped to keep the Hospital going. Their destruction meant great financial difficulty but in this very bitter moment both Mr. Humphery and Mr. Lees Read saw the opportunity which the destruction made possible. Before then, plans for rebuilding Guy's had been confined to the site of the Hospital as it then was, contained within the area of St. Thomas's Street, Great Maze Pond, Newcomen Street and the Borough High Street. Now the destruction of the buildings on the adjoining land as far as Weston Street made possible the use of this site for the new Guy's which was planned for after the war. Where land was not already owned by the Hospital, negotiations were opened to buy and this policy was pursued over the years so that when war ended nearly all the site was in the Hospital's possession. The Governors were grateful for the help they had received from various authorities, as well as private individuals, in consolidating

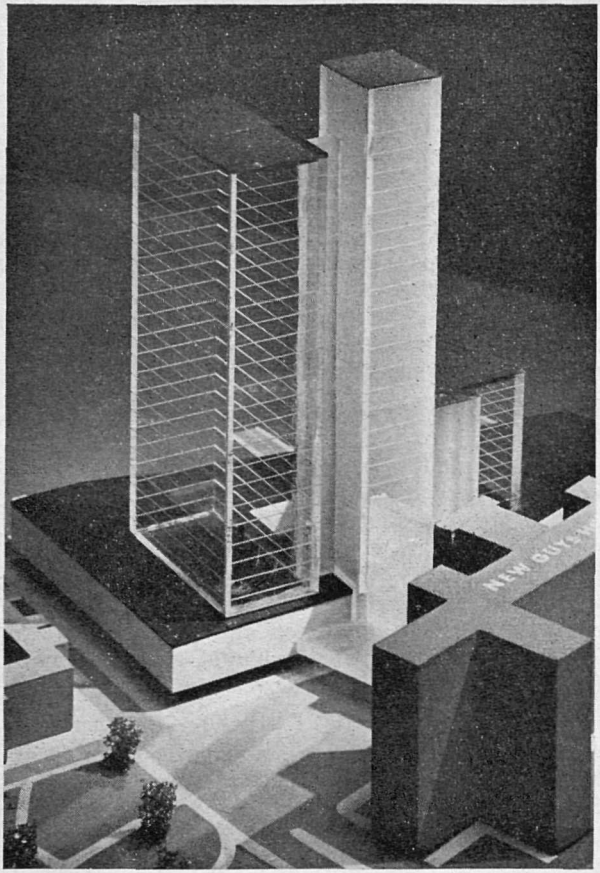
their ownership. Planning continued after the war and with the start of building of New Guy's House in 1957 the first stage in the centralisation of facilities for the care and treatment of patients on the new site was begun. With its fourteen surgical wards, new theatres and other departments, its primary purpose was to replace the accommodation which for more than 230 years had been provided in Guy's House. This at the time was the most urgent need and, once met, attention was then turned to planning the remainder of the site in such a way that succeeding needs would also be met in order of priority and within an overall plan. It was most important that development on a site which is probably unique in London should not become piecemeal and that opportunism should not be allowed to overrule the orderly redevelopment of the Hospital. In 1961, when New Guy's House was completed, there were five or six main needs which had to be met in the next stage of rebuilding.

First was the urgent necessity to build new accommodation for the Dental Hospital and School, itself a vast out-patient department handling more than 150,000 patient attendances a year and training upwards of 400 students at any one time in accommodation the first portion of which was built in 1888. It had grown piecemeal over the years by enlargement, encroachment and pressing into service such unlikely buildings as the bacon factory, the laundry maids' hostel, a hop warehouse and, more recently, an extension on stilts over the railway premises in George Inn Yard and a wooden hut with Riviera blinds on one of the flat roofs. The total floor area of the present conglomerate buildings is little more than 35,000 square feet and the area which is now considered necessary for the work of this vast department is more than 120,000 square feet.

The Department of Clinical Pathology raises another acute problem. It is at present situated in accommodation which is let to the Hospital by the Medical School and is far away from wards and the Out-Patient Department. The 5,000 square feet it occupies, though badly needed by the Medical School for its own expansion, is totally insufficient to allow clinical pathology to develop as it should. Present-day practice requires an area of nearly 32,000 square feet to provide a proper laboratory service for this Hospital.

Several years ago the Spastics Society endowed the Prince Philip Chair in Paediatrics at Guy's Hospital and most generously agreed to contribute to the cost of research laboratories for the Paediatric Research Unit. They also agreed to help meet the cost of providing new wards for the treatment of children at Guy's. These would replace the accommodation now provided in the Evelina Hospital and in Caleb and Diplock Wards so that laboratories and wards could be closely associated within the new building. New facilities are urgently required and delay inevitably reduces the value of this substantial gift from the Spastics Society as building costs rise.

The need for new obstetric wards is great and this coincides with the requirements in this area for more maternity beds. In planning the maternity services for South-East London the Regional Board and the Ministry of Health are in agreement that 100 obstetric beds should be provided by Guy's.



The model of the Tower Block, showing its relation to New Guy's House. Hunt's House has been "vacated"

When New Guy's House opened it had within it a small specialised X-ray Department for cardiac and neurosurgical work. All other X-ray work had to continue in the department on the ground floor of Hunt's House, involving a long and difficult journey for patients from the surgical wards. Good hospital planning places the X-ray department together with the other reference department, clinical pathology, as close as possible to the physical centre of the complex of buildings in which patients are treated so that travel distance, both for patients and staff using these facilities is reduced to the minimum.

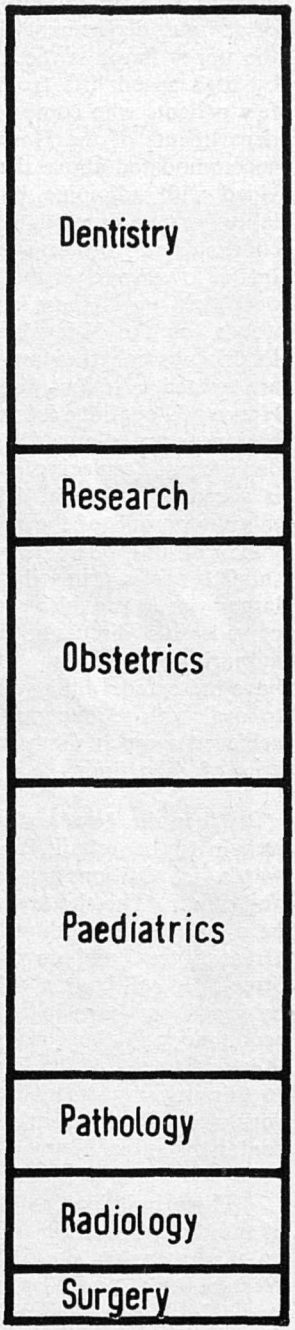
New Guy's House contains eight theatres and increasingly complicated theatre work makes it clear that more theatre accommodation is needed for the fourteen surgical wards: also that special facilities must be provided for intensive care and recovery as well as for the reception of emergencies. All this must be in the closest relationship with existing theatres.

The Governors have over the years contributed considerable sums from the Endowment Fund to the maintenance of medical research at this Hospital. Nearly all this money has been in the form of grants or

salaries for research staff or for the purchase of equipment. The Governors now feel it is time that proper research accommodation should be provided and in helping to achieve this they are prepared to consider making a substantial contribution from the Endowment Fund towards the overall cost of the next phase.

Finally, the Hospital's steam supply, without which all existing buildings would have no heat, no domestic hot water, no central sterile supply service and only the use of a small part of their cooking equipment, is at present provided by five Lancashire boilers, four of them between 60 and 70 years old, and two water tube boilers. The latter boilers were designed for export immediately before the last war. They were built to burn brown lignite and were installed as an emergency measure in 1951 to help keep the steam services going until a new boiler house could be built. In a report by the Hospital's Consulting Engineer in 1962, the Governors were told that the age and condition of this plant was such that a new boiler house had to be in operation within seven years. In the plans for the area is a road widening scheme for the Borough High Street which will cut into the existing boiler house. A new boiler house must be sited away from its present position and should be situated as near as possible to the main buildings which it is to serve.

The Tower Block, as now planned, meets in the most logical way that may be found, all the needs which have been mentioned and puts them, as far as the Hospital's planning team can determine, in their right position in relation to what already exists and what is still to come. It provides some 26 working floors, all air conditioned, as well as floors occupied exclusively by plant and equipment and will stand, as the plan on page 128 shows, immediately to the north of and connected to New Guy's House. The new boiler house and its ancillaries are, as with many modern office blocks in London, beneath ground level, out of sight and sound and unknown to all except the initiated. The stack serving it runs up inside the building itself and all smoke and fumes are



Spatial plan : Tower Block

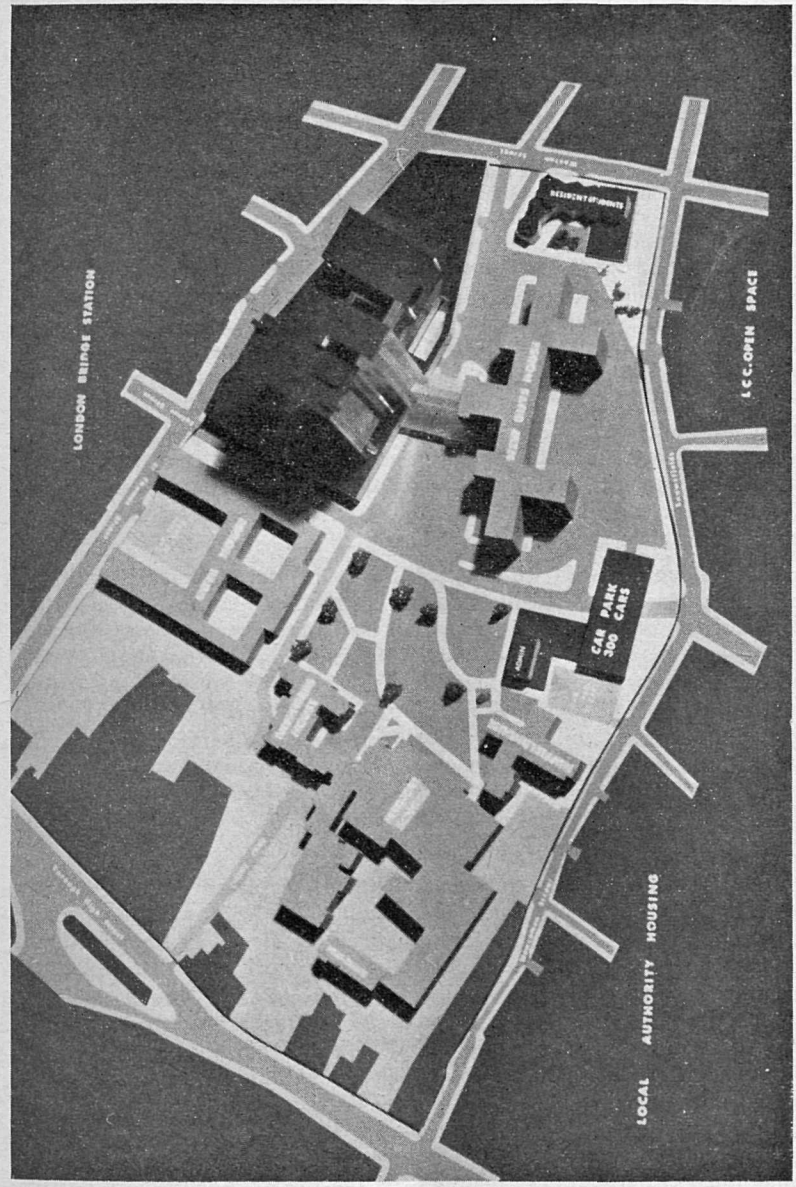
emitted at a height well above the surrounding buildings. The position of various departments in the building has been carefully chosen. On the upper floors is the new Dental Hospital and School served directly by high speed lifts from ground floor level. Statistics show that very few patients who come for dental treatment need to be referred to other departments of the Hospital. The Dental Department is therefore best accommodated above the point where cross communication may be provided with adjoining buildings. Beneath the dental floors is research laboratory accommodation and lower down are the floors accommodating children's and obstetric beds together with further research laboratories. In the lower part of the building with cross communication to all floors of New Guy's House and to the future out-patient block and medical wards are the X-ray Department and Clinical Pathology laboratories. In this position they are in close relationship to areas in which patients are treated. At first floor level the existing theatre floor in New Guy's House will continue into the Tower Block. At ground floor level the main entrances are planned, together with lift halls and a new ante-natal department (replacing Salomons Centre). At lower ground floor level is a central cafeteria. The shape of the building, as can be seen from the photograph of the model on page 125, is in the form of two towers, joined at all levels, one with a floor area roughly half of the other. The small tower is primarily designed to contain lifts and services while the larger tower provides working space. This shape was arrived at after considerable discussion with the London County Council as planning authority for London. The alternative of a monolithic building would have presented a bulk which the planners felt would be extremely difficult to deal with architecturally. The twin tower building has in their view achieved a much slimmer appearance without a reduction in the overall area of each floor.

When the Tower is completed two major sections of the Hospital will remain to be rebuilt, a new out-patient department and new medical wards, in addition to ancillary accommodation such as kitchens, stores and offices. The site layout plan on page 128 shows that out-patients will be a four-storey podium around the base of the Tower stretching from Great Maze Pond down St. Thomas's Street nearly as far as Weston Street. It will have a bridge over St. Thomas's Street for those coming by foot from London Bridge Station. The medical wards and ancillary accommodation are planned as a third block between the Tower and Weston Street. All buildings in this complex are linked at common levels. In this way movement between departments is made as easy as possible with swift lift transport for each main block and relatively short horizontal distances between the blocks themselves.

These buildings as planned provide generally for the redevelopment of the clinical facilities of the Hospital over the next ten to fifteen years on the extension site. There is left an area of land in the corner of Weston Street and Snowsfields which the Governors are able to make available to the Medical School for the erection of a students' hostel. This development is, of course, the responsibility of the Medical School but the Hospital is prepared to collaborate in the provision at Endowment

Fund cost of an auditorium in this building which might be used for meetings of learned societies, for plays, for prize-givings and for other functions. The Governors propose that this shall be called the Cunliffe Auditorium in memory of the late Chairman.

In order to secure town planning approval for the scheme, particular attention had to be paid to car parking space. This is provided to a



Projected plan of the whole Guy's Hospital site

scale which has been worked out by the London County Council. In the overall scheme a multi-storey car park is suggested on the Snowsfields side of the site where the main entrance of the future might best be provided when road widening and other traffic improvements in the area have been completed.

The massing of the various buildings is one in which the planning authority has been most concerned and the development at Guy's has been carefully related by the L.C.C. to their own 22-storey residential developments near Long Lane and also to the buildings which are now in the course of erection close to London Bridge Station. Planning of the Tower has now advanced sufficiently for a target date of 1966 to be set for the stage by which most detailed planning will have been completed and a final cost known. At present this is estimated at rather more than £5,900,000.

In 1963, the next phase of development at Guy's was included in the Ministry of Health's ten-year capital programme in the second five-year period and it has recently been said that commencement of building is not planned before 1970 or 1971. In the Governors' view it is essential that building should commence much sooner if the most urgent needs of the Hospital are to be met before they become critical. Building the Tower may well take 3—3½ years and the following phases could require another 6—7 years to build in addition to the time required for planning. Guy's is fortunate in having a site available. It is fortunate also in being able to expect contributions towards the cost of this development from sources other than the Ministry of Health.

The difficulties with which the Ministry of Health and the nation at the present time are faced in financing hospital capital developments are appreciated. But unless this problem is overcome the possibility of catching up in the enormous task of rebuilding the hospitals in this country becomes increasingly remote. Statistics are sometimes startling. Dr. Brian Abel-Smith, who with Professor Titmuss provided the statistical background to the Guillebaud Report on the Health Service, has recently said that the proportion of the gross national product now invested in hospital capital development in this country each year is less than it was immediately before the war and is proportionately less than that of any other country which publishes comparable statistics.

In this article current achievement has been related both to the past and to the future in general terms. Planning for the Tower Block under the direction of a Governors' committee, led by Mr. A. E. Orchard-Lisle, Vice-Chairman of the Board, is centred on the work of the project team. This in turn is led by Dr. P. J. Helliwell, with Mr. P. Le Fleming, Assistant Clerk to the Governors, helped by Mr. J. D. Hague and others who all work together in closest conjunction with the Hospital's professional advisers. The Architects are Messrs. W. H. Watkins, Gray and Partners, the Consulting Engineers for Mechanical Services—Messrs. L. J. Schwarz and Partners, the Consulting Engineers for Structure—Messrs. R. Travers Morgan and Partners, and the Quantity Surveyors—Messrs. Eric G. Lynde and Partners. Many members of the medical, dental and nursing

staff are giving long hours of their time working on the details of the various departments and out of this will emerge the next and perhaps the most exciting stage of the rebuilding of this great teaching hospital. It is hoped that members of the planning team may be able, as plans develop, to give readers of the *Gazette* a glimpse into the problems which they have to overcome. Those who are lucky enough to take part in planning the Tower Block will need all the knowledge and technical skill, foresight and judgment they have. But their greatest asset will be unbending determination and strength of purpose to achieve their end.

Guy's Hospital Dental Society Annual Dinner

Members of Guy's Hospital Dental Society spent a very full and interesting day in the school and local pubs. before retiring to the Park Lane Hotel for their 59th Annual Dinner. After two royal and loyal toasts, Professor P. O. Pederson from Denmark spoke with unique freshness and wit, telling us what he was going to tell us, and added a Socratean shaggy-dog story to boot. He spoke of the high respect held for Guy's dentists throughout the world. Mr. F. S. Warner replied for the Hospital and Schools by telling of the decrepitude of the dental premises which a "ministerial" guest had aptly called 30,000 square feet of slum. Mr. J. W. Mansie mentioned the impending retirement of "Sir Bo", and added that every Dean should have a blind eye to turn. In reply, Surgeon Rear Admiral W. Holgate, representing the Ministry, expertly evaded any remarks that could be quoted as an official statement. Professor M. A. Rushton then spoke of the work of Professor Herbert, who has been three times President of the Society, and to whom many Guy's graduates and students owe their thanks. Tim Negus, as Secretary, gave a polished *ad lib* speech which culminated in a very funny consultoid joke. The whole company then retired to the bar.

JOHN VERNON CLARK

John Clark, who died at the early age of 54 and at the height of his career, followed the best traditions of Guy's-trained consultant practice in Tunbridge Wells as Ear, Nose and Throat surgeon.

He was born in 1910 in Darlington, into a family with a strong engineering establishment. After education at Durham School he started his engineering training but quickly came to realise that as he made progress he would soon cease to be a "do-er" and would become more of an office executive. This line of thought led to his choice of a medical cereer and he entered Guy's in 1930, qualifying in 1935. During this time his outside interests were in rowing and tennis, in both of which he excelled and represented his Hospital. Among House appointments he spent a year at the Derbyshire Royal Infirmary where Robert Flett (also a Guy's man) stimulated his interest in "ENT". He went on to Edinburgh where he gained his Fellowship, returning to Guy's as Registrar and the Chief Assistant to the Throat and Ear Department, working also in the L.C.C., experience in "fevers" being then essential to E.N.T. training.

His connection with Tunbridge Wells began just before the outbreak of war and was interrupted as he served in his specialist capacity in the Army in India and in the Middle East and Italian campaigns. Returning in 1947, he re-established his practice and from then until his untimely death he maintained an immaculate standard of work which derived from his unswerving professional perfectionism.

Those who were privileged to work with him respected and hoped to emulate him. One of his patients wrote to the *Kent and Sussex Courier* shortly after his death—"I was seven times in his operating theatre and I write with conviction of his skill, popularity and dedication and I, with many others shall miss his generous and comforting personality": John, as a "do-er" would have appreciated these words. Our deep sympathy is extended to his wife and son.

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Dental Secretary: Frank Allott, LDS

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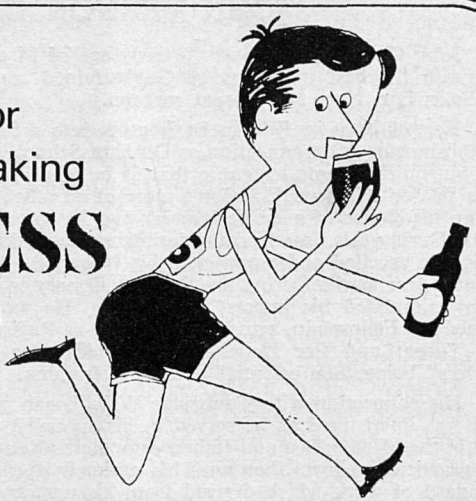
Tel: LANGHAM 9241

Dear Doctor
I have been taking
GUINNESS
for seven
days
running



and how much better I feel!

THE EXCHANGE PROGRAMME BETWEEN THE MEDICAL INSTITUTIONS OF

Mr. Thomas Guy of London and Mr. Johns Hopkins of Baltimore

SAMUEL P. ASPER

PROFESSOR OF MEDICINE AND ASSOCIATE DEAN
THE JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE

Mr. Thomas Guy, of London, and Mr. Johns Hopkins, of Baltimore, had much in common, although their lives were separated by 150 years and a great ocean. During long lifetimes of hard work, they amassed great wealth. Leading frugal lives, they were thought by some to be miserly, but neither denied himself the modest comforts of home and a servant or two. They shared compassion for the sick of body and poor of spirit and, although making modest benefactions during life, they directed that their fortunes be used upon their deaths to establish institutions of healing and learning. Some present-day wits have said that Guy and Hopkins were able to accumulate such great fortunes because neither afforded himself the luxury of a wife, but the truth is that both were clever in business and prudent in investments. Among their friends were wise, intelligent people who gave them good company, sage advice and wise counsel. How fitting it is, then, that the two great medical institutions they founded should join hands in an affiliation which has proved so mutually beneficial. This is the story of how the affiliation came to be and what it has produced.

In late August, 1946, a letter was received at The Johns Hopkins University School of Medicine from Dr. E. R. Boland, Dean of Guy's Hospital Medical School. The letter, addressed to the late Dean Alan M. Chesney, contained a simple proposal for an exchange of faculty between the two schools. Dean Boland wrote to Dean Chesney as follows :

> " A short time ago the Medical Committee of Guy's Hospital had the idea of exchanging clinical teachers with those of an American hospital. Their hope was that it would be possible for an annual exchange, so that one member of all the Surgical branches and one member of all the Medical branches of an American hospital should come to Guy's and act in all respects as members of the Guy's staff for about a month, and that corresponding

members of the Guy's staff should go to an American hospital for the same purpose and period.

The object of the exchange would be to maintain the friendship, co-operation and exchange of ideas which has been one of the better things which have come out of this War, and of which so many of our joint Staffs have so much personal experience.

The Company of Clothworkers, one of our old City companies, has had the generous imagination to see the value of this proposal and has granted . . . . financial expenses.

Many Guy's men have derived great advantages and have happy personal memories of former associations with your great Hospital, which is, in consequence, well known to us either by personal contact or by hearsay, and we should value a closer association with you of the nature proposed.

I am writing formally to propose such an association to your faculty and . . . . (to) find out whether they think it both desirable and feasible . . . "

Dean Chesney discussed Dean Boland's proposal with several members of the Johns Hopkins faculty. The response was unanimously enthusiastic. The President of The Johns Hopkins University, who at the time was Dr. Isaiah Bowman, approved of the plan and, on October 12th, 1946, Dr. Chesney was able to write Dr. Boland :

" Your letter of August 28th . . . was brought to the attention of our governing body, namely, the Advisory Board of the Medical Faculty, at its meeting held October 1st, 1946. I am glad to inform you that the Board expressed great interest in the proposal, and voted unanimously to recommend that the exchange be put into effect, provided the necessary arrangements can be made . . .

I would like to say . . . how greatly interested our faculty is in this proposal, and that we welcome it wholeheartedly."

One or two additional letters were all that was required to begin an exchange of senior faculty which has proved over these 18 years to be a successful, happy and productive one. Deans Chesney and Boland continued, however, to correspond with each other concerning the selection of faculty for the exchange and the mechanics of its operation. Their wisdom and foresight enabled them to see that such an exchange of faculty would reap profits far beyond its reasonable cost.

During the exchange, the professors have carried out exactly what Sir Rowan Boland hoped for. In teaching, visiting laboratories and seeing patients, they have used their talents as each deemed best. Accepted as members of the host faculty, each has come to know his

opposite faculty members quite well. The lectures, demonstrations, conferences and operations given by the visitors have added strength to the curriculum and have been well received by students and staff. In such a free exchange the strengths as well as the weaknesses of each school are made more apparent, and constructive criticism, readily accepted by both faculties, has been an invaluable by-product.

The program has not been without its lighter moments. The head nurse on a Johns Hopkins surgical floor, unaware that British surgeons are known as "Mister" and not as "Doctor", mistook Mr. Hedley Atkins for one of our medical students, and let him know in precise terms what his limited prerogatives would be on her floor. On another occasion, the late Dr. Joseph Earle Moore, of Johns Hopkins, when at Guy's, learned that he was being secretly kidded about his middle name by several Guy's students who questioned his title of "Earl". Dr. Moore, with characteristic good humour, told them that his middle name was the choice of his parents and implied no degree of nobility. Not that being titled was closed to Americans, he added, reminding them that in the United States there is a popular conferral of nobility on such persons as Count Basie and Duke Ellington, and even on the regal but simian movie star, King Kong.

At Johns Hopkins we have always been interested in what led to Dr. Boland's proposal for the exchange. In response to an inquiry in 1960 by Dean Thomas B. Turner, the late Mr. Lees Read, then Clerk to the Governors of Guy's, provided the following answer:

> "I think it was in 1945 that I attended a luncheon of the Clothworkers' Company as a guest of the late Mr. John E. Humphery, then Treasurer of the Hospital, and after lunch there was a report from an officer who, I believe, was titled 'Chairman of the Committee of Almoners' of the City Company." He reported on their income and various proposals for using it. Included in these was a suggestion that a considerable sum of money per annum should be set aside for an exchange scheme between an English and an American University under which students should visit the respective countries and study methods of producing and finishing cloths.
>
> I happened to have been born and brought up on the borders between Lancashire and Yorkshire, i.e., between the two big cotton and wool manufacturing areas of this country, and I commented to Mr. Humphery that most of the worthwhile knowledge connected with the processes involved in the manufacturing of cloth were trade secrets of the firms carrying out manufacture, and I thought it highly unlikely that the exchange would really do a great deal of good.
>
> The Clothworkers' Company is wealthy and Mr. Humphery then said to me: 'If we can't establish scholarships to study the manufacture of cloth, can you suggest

an alternative?' I suggested medicine, pointing out that there were really no trade secrets, except possibly methods of manufacturing drugs, and further, I suggested that an exchange of teachers rather than students would bring greater benefit to the participating institutions.

Some little time afterwards I was informed, officially, that the Clothworkers' Company would be prepared to finance such a scheme, and this was the beginning of the exchange scheme between the Johns Hopkins Hospital and Guy's Hospital. Mr. Humphery died about, or possibly just before, the time that the first exchange took place, and in the Clothworkers' Company records the exchange scheme is always referred to as the 'John E. Humphery Exchange Scheme.' "

Since 1947, 35 members of the Guy's faculty have visited Johns Hopkins, and 26 from Johns Hopkins have visited Guy's. (A list of these faculty members, including those selected for exchange in 1965, will be printed in the next *Gazette*).

A happy but unexpected development of this reciprocal programme has been its effect on younger members of the Johns Hopkins and Guy's faculty and student body. No less than twelve Registrars of Guy's Hospital have come to Johns Hopkins for periods of one or more years of additional training. Conversely, almost twenty-five Johns Hopkins medical students have spent elective periods of study at Guy's. The goodwill and understanding developed as a result of this cannot be measured. Many of these Registrars and medical students have continued in productive academic careers and, often, have published scientific papers on work conducted during the period of their fellowship. The Humphery Exchange Scheme has paid an unanticipated dividend.

A list, hopefully complete, of those Registrars and students who have worked in the affiliated school is shown in the table. It is important to note that funds to support these exchanges have come in many instances from personal sources of the visitors, from the medical schools and hospitals, and from charitable organizations.

Thus, the influences for good which the faculties of these two venerable institutions have had on each other have been gratifying. Are there ways, then, in which programmes of similar design with other institutions, especially those of the developing countries, might prove beneficial? That the British are taking a new look at such projects is attested by the brilliant report, "Medical Aid to the Developing Countries", published recently by a working party under the leadership of Sir Arthur Porritt, K.C.M.G., K.C.V.O., C.B.E. In the United States, the Association of American Medical Colleges has established a division for international medicine under the capable direction of Dr. Henry van Zile Hyde. At Johns Hopkins we, too, have attempted recently to reassess our role and responsibility in providing medical education and experience for students and physicians from overseas schools and hospitals which are striving to attain new standards of scientific and humanitarian medicine.

Since World War II there has been a remarkable increase in the number of doctors in post-doctoral training at Johns Hopkins. The size of the House Staff of the hospital, now numbering 272 persons, has nearly doubled, as the hospital has increased its facilities and entered into rotation plans for house staff with affiliated hospitals in the city. Moreover, prior to the War, only a handful of doctors were in special training programmes; now there are 269 who are on research or training fellowships. Thus, nearly 550 post-graduate "students" are currently enrolled at Johns Hopkins—a number exceeding that of our medical student body which, although recently also increased in size, is only 385 students. Among our post-doctoral students are 172 who come from abroad, and among our medical students there are 8.

The remarkable growth of the post-doctoral programme led Dr. Milton S. Eisenhower, President of Johns Hopkins University, to establish in 1959 a standing committee on post-doctoral education. The need for extending and improving our work in this area became apparent following a study initiated by Dean Turner. The recommendations set forth in this study called for improvement of the manner of selection of physicians from overseas, especially of those from the emerging countries. Requesting the Commonwealth Fund of New York to support our affiliation with medical schools in each of three developing areas of the world, we proposed to pattern these after that which has operated so successfully with Guy's. The Commonwealth Fund made generous grants for this purpose, and within the past two years Johns Hopkins has established affiliation with the University of Ibadan in Nigeria, the American University of Beirut in Lebanon, and the Peruvian University of Medical and Biological Sciences in Lima. Two Johns Hopkins faculty members go to each of these schools each year, and one or two of the faculty of the affiliated schools visit us. In view of the great distances of travel and the time required to understand the operations of these schools, each of our professors visits for a period of three months, rather than the one-month period as with Guy's.

Recognizing the enormous good in the cross-training of younger men, which was an unexpected development in the Johns Hopkins-Guy's exchange, and the need to improve our foreign post-doctoral programme, we decided to structure the Commonwealth Fund exchange to achieve these ends. Thus, the keystone in this newer exchange is the selection of outstandingly qualified young physicians from the overseas schools for additional training at Johns Hopkins. It is expected that after one to three years of such additional training these physicians will return to their own medical schools to take permanent academic positions. Indeed, only those who have manifested an interest in academic careers are selected.

Although it is much too early to determine positively whether this Commonwealth Fund programme will achieve the same success as the Guy's-Hopkins exchange, there is evidence that certain beneficial effects have already occurred. For example, we note that more

rigid criteria for the acceptance of post-doctoral fellows have been adopted by the members of our faculty accepting physicians for advanced training. This "tightening up" holds true not only for post-doctoral applicants within the United States, but also those from abroad as well. Our teachers and investigators are more likely now than formerly to make certain that those they accept come with outstanding recommendations, that they have expressed a desire to return to their own country upon completion of their training, and that a post is to be provided for them if their performance merits it.

Although funds available to most medical schools in the developing countries are limited for establishing full-time teaching positions in both basic and clinical sciences, there appears to be steady improvement in the procurement of such funds. Moreover, facilities and equipment for first-class research laboratories are also limited, but through grants of governmental agencies and gifts from charitable organizations, such facilities are increasing. Thus, it seems important to have at least a few exceptionally well-trained persons who are ready to step into faculty and research positions as they become available in their emerging nations.

The Advisory Board of the Johns Hopkins Medical Faculty and the Medical Board of The Johns Hopkins Hospital are solidly behind these new affiliations and hold that they in no way alter our long-established affiliation with Guy's Hospital. Indeed, it is hoped that these newly-established affiliations will serve to strengthen our relationship with Guy's. We can foresee, for example, that certain outstandingly qualified doctors from the developing countries might include periods of study at Guy's, in addition to their training at Johns Hopkins.

We are of the firm opinion that the Humphery Exchange Scheme of the Clothworkers' Company has resulted in remarkable advances in international medicine. Besides the fine relationship the exchange has fostered between Guy's and Johns Hopkins, it has provided the model for a whole new approach for accomplishing an orderly and sensible expansion of the Johns Hopkins post-doctoral programme.

Art Society

The Art Society warmly invites all students, members of the hospital staff and their friends to a lecture on " Some Aspects of Children's Art", to be given by Mr. Eric Austen, lecturer on Art and Craft at Southlands College. It is to be held on Thursday, 25th March, at 5.30 p.m., in the South Common Room of the East Wing. Mr. Austen will be talking about the subject from a developmental, as well as from the artistic angle.

Catholic Society

On Tuesday, 23rd March, at 5.30 p.m., the Society has invited to Guy's, Father Lawrence Bright. He is that rare combination of churchman and a scientist, and his views in a discussion on the subject " DOES GOD EXIST?" should be thought-provoking and useful. The meeting will be held in the Students' Club, and anyone who is prepared to rethink this problem and to re-examine the evidence is invited to attend.

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THE RESIDENTS' PLAY

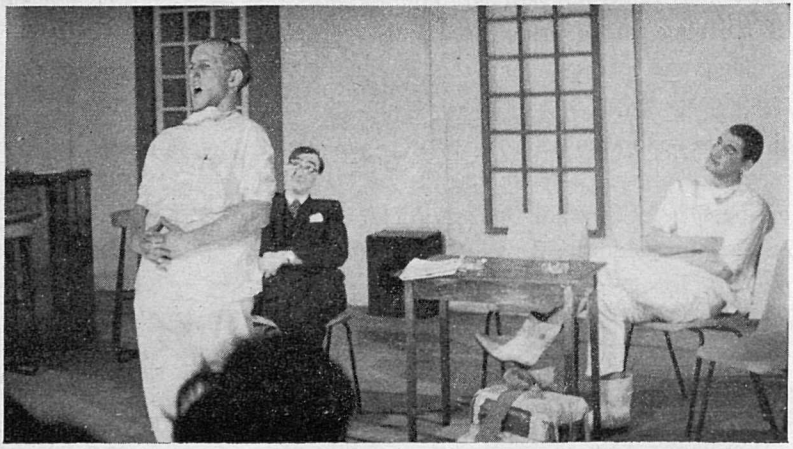
1965

"EXPERIMENTAL ANIMAL FARM"

Once again that yearly phenomenon unique to Guy's, the Residents' Play, has been performed nightly before enthusiastic audiences in the Physiology Theatre. " 1965 or Experimental Animal Farm " by Christopher Mallinson was a very good play. The plot was good, the script was witty and was always in keeping with the characters portrayed, and the play was entirely traditional, for which we thank him. The words and music (by A. E. Davis, I. D. B. Rennie, S. R. Meadow, K. M. Pagliero and P. G. Inward) in the modern "musical" tradition enhanced and integrated well with the action and the plot, and the general production (T. C. Davis and I. Vadasz) was smooth, efficient and imaginative. It is traditional in reviewing the play to give a synopsis, for the record, before any general comment. This is also an interesting exercise, as in some plays of past years the plot still remains unsolved.

It started off with a bang with the opening chorus of Mods. These were sexy Mods of the old school, heavy lidded and voluptuous, who were enjoying their fate in the East Wing.

From there we go to the surgeons' sitting room, where one, SAM HOSS, is having trouble with a crossword, and the other, MANDY SMEARED, is attending to his appearance in preparation for a broadcast from Honest John. A Rover parked in front of the Superintendent's house has been crushed, and Hoss goes along to pick up the bits. SCURRY FUNCTIONER arrives and after confusing Smeared with the house surgeon (" I only get the headlines down at my place") points out that there is no Big Brother trouble where he is, as he is Big Brother. Hoss declines to accept lunch at the Maudsley with all those psychiatrists, but sings.



SAM'S SONG
(Sam Hoss)

My chest expansion's somewhat nil,
I always use a lift.
I love my weeds, for though I'm fagged,
Tom Hills is all Wills Whiffed.
I roll my own from side to side,
a trick that few can do,
It is given to the few, Ho, Ho, Ho, Ho, Ho, Ho.
'Tis given to the few, the few, the few.

My evenings pass before the screen,
(T.V. and nineteen inch).
Kind fate has insulated me,
I'll never feel the pinch.
Straight as a rectum they will say,
I think that this seems fit,
Behold my epitaph is writ. Ho, Ho, Ho, Ho, Ho, Ho.
My epitaph is writ, is writ, is writ.

While Guy goes Middle Eastward,
I will probably go West :
Assassination is his line,
and at it he's the best.
Discriminating surgeons like old Hedley, keep abreast,
While I am feathering my nest. Ho, Ho, Ho, Ho, Ho, Ho.
I'm feathering my nest, my nest, my nest.

No psychic problems cloud my mind,
I have a surgeon's phlegm :
I operate if needs I must—sometimes not even then.
I love the Nurses, tease the Students,
call the Sisters "Dear",
No physician is my peer. Ho, Ho, Ho, Ho, Ho, Ho.
No physician is my peer, my peer, my peer.

JOLLY MORMON also arrives from doing a rather large skin biopsy ("That's not so much a skin biopsy, that's more a slice of life") announces his infatuation for JEAN YAWS, the Theatre Sister, and sings of the 1930's.

THIRTY-THREE YEARS GONE
(Lolly Mormon)

Nineteen thirty-two, a vintage year.
It was the year that was made consultant here,
Now in sixty-five I do not thrive.
The flappers aren't the same I fear.
There were bright young things in flannel bags,
On trams that ran in the High Street,
There were aero stunts and treasure hunts
When you'd tired of the movie show,
(How I long to be back in the days of Garbo)
It can't be wrong to sometimes long,
When it's only thirty-three years gone.

I'm very glad and not surprised
That skins and things have kept my mind so occupied.
I've made lots of pastes, creative pastes,
With bases out of Picic Carb.
I'd Ung, Hydrang, in pots so large
And Pot. Permang. in magnums.
The magic's flown with cortisone,
My golden days were long ago.
(What a life of scratching it has been here at Guy's.)
It can't be wrong to sometimes long.
When it's only thirty-three years gone.

Mormon wishes the Theatre Sister to be transferred to Hunt's House. The surgeons approve this idea ("and we could start operating again") and leave to see the Superintendent in his lair. In this scene we are also introduced to our heroine, Staff Nurse Miss POLLY ARTERITIS, and we know we are going to like her. She is tall, extroverted and generous-hearted. She is also American and has eye-lashes that a camel would be proud of.

In the tranquil atmosphere of the Athenaeum, PROFESSOR BATTLEFIELD has been entertaining READER BOUNCE to caviare ("I liked that fishy jam on rusks") and devilled kidneys ("the cortex was a bit knocked off"). It appears that there have been lots of signals about a new Minister of Health and Battlefield is definitely interested.

THE SHAMATEUR PROFESSOR
(Prof. Battlefield)

Everybody says that I'm the person to be the Minister of Health,
Everybody says the Government wants me : I confess they need my stealth,
I have plans for the country's greatness; I have plans for the Nation's good,
I have plenty of plans for Guy's and quite a few—for John.

Woolwich is the centre of my schemes for General Practice controlled by one,
Three thousand patients for Guy's students; six thousand kidneys for Stewart and John,
All the night calls will be done by Junior Medical Registrars,
Whilst the capitation fees are wending their way—to John.

Parliament will wonder what has happened when I use my research kit,
Senior members will find out that they're so ill they have to quit,
Clinitest on Alec and Reggie; Acetest on Harold and George,
Phenistix on Liberal Joe makes lots of openings for John.

What a splendid trio we could be; Harold, George and especially Me,
Though tomato ketchup makes me wonder if one would not be better than three.
I'd hate to wear a tartan mac; and I'd loathe to adopt a Northern voice,
So when they're ill I'll look after them—soon there will be Just John.

To further his aims it is proposed to kidnap the Parliamentary Secretary of Health due at the Superintendent's Office next day. Bounce's job will be to keep him sedated in William Gull, and he is to be helped by JAMES RUNT, Single 0-7, special agent, who has been posing as a Professor of Physiology for many years. In order to bribe the Superintendent to push his claim in the right quarters, Battlefield has installed a closed circuit television at Guy's, which should be ideally suited to Superintendent Big Brother's tastes. They try the master screen and see our two surgeons taking a shower; they learn of their plan to transfer

Sister Yaws to the medical block as chief overseer of medical experimental procedures. This must be stopped. She must also be kidnapped, and someone must impersonate her. Who? CHARLES GROINER arrives in answer to their prayers. He is splendidly attired for the shoot ("playing at Gamekeepers again?"). After sizing up the situation he makes his decision quickly and clearly—"I take size 12 black nylons and what are we waiting for?"

In the Superintendent's Office a Dalek has taken charge; the Superintendent is so weak from sixteen committees daily he has been admitted to the Chelsea Hospital for a rest. This is a real live Dalek, straight from Dr. Who, and what's more the head Dalek—the black one. As Battlefield's security dossier is in order and the offer of his Big Brother Television most acceptable, the Dalek agrees to support Battlefield's ministerial ambitions. James Runt disposes of SIR EVELYN TENSION, Parliamentary Secretary, with a professorial display of unarmed combat, and Charles Groiner is now effectively disguised as Sister Yaws, the original being in a linen basket in the Nurses' Sick Room; but he is surprised to find that he has attracted Mormon's attentions to an alarming degree.

After the interval we have the conspirators' song . . .

Battlefield :

We're near the final count down boys,
but don't tell anyone.
So follow me that I may win, but don't
tell anyone.
I've jobs for you and Charles and James
as you will shortly see,
We must all pull together for the benefit
of me.

Chorus :

Revolution, revolution is our strongest
resolution,
Come and see if you need it,
And we will help to lead you to it,
Counter plot and double bluff are bread
and butter stuff to us.
We do not doubt that each will win,
But don't tell him.

Runt :

I follow the Professor pretending he's
the chief,
But I'm in fact a sort of thief set to
catch a thief.
I should end up all powerful, despite
Professor John,
I might become a Governor, but don't
tell anyone.

Polly :

I do not chase the man you think, but
don't tell anyone,
I'm following Charles Groiner, but
don't tell anyone.
When I was ill in sick bay, how the
memories persist;
The sexy way he flicked his specs, I
really can't resist.

Functioner :

I wish they wouldn't always act as if
I wasn't here,
It's not as if the Maudsley wasn't really
rather near,
House surgeons sometimes put up drips
when they think I've gone,
I return and take them down, but don't
tell anyone.

Bounce :

I really haven't got a clue what is going
on,
I really haven't got a clue, but don't
tell anyone,
I'll listen to the others and will learn
their point of view,
And then perhaps I'll understand what
I ought to do.

Groiner :

This trek is rather curious for people
of our age.
I can't think what we're doing running
round and round this stage.
I'm a keen and earnest teacher but no
athletic Don,
I'm not a Beckenham Harrier, but don't
tell anyone.

Battlefield :

It's a glorious feeling being leader of
this team,
A more loyal bunch of chaps I'm sure
there's never been.
They're on a sticky wicket now, but
don't tell anyone,
The only one who'll have a chance to
make a score is John.

We then find DR. GERALD SPAWN at home in his magician's cell. He is relieving his tension by taking it out on a cushion, and giving guidance to Polly Arteritis and our hero, Dr. Groiner's H.P., Mr. APE EARIENT. The latter is a bare-footed, ape-like creature and it is difficult to know what she sees in him—it can't have been his sign-ups. They all sing a magic love song which is most effectively staged with ultra violet light. Mormon also seeks Spawn's help to predict a romantic future, and Bounce subtly persuades Spawn to remove the troublesome Sir Evelyn from William Gull to Functioner's care at the Maudsley, ("Super idea, Gerry. Just the job.")

It is now night time on the roof of New Guy's House. Night Sister KIX disturbs the hero and heroine and sings of her vocation.

LIVING FOR KICKS

(Sister Kix)

Of noble girth,
And solid worth,
I plied the nurse's art.
With strings attached,
I was unmatched,
A sister quite apart,
My sturdy frame
Might yet remain
To tread the creaking boards.
Yet I did roam,
This earthly home,
My thoughts long fled the wards.

Matron might glance
Somewhat askance
If I revealed my dreams.
I knew the ropes,
So hid my hopes
Beneath these bursting seams.
I rule by right
The H.P.'s night,
The patients' just the same.
Nocturnal flower,
My vice is power,
Within a homely frame.

Chorus.

Pushing paraldehyde, peddling the dope,
Dishing out ecstasy, happiness, hope.
Jacking up junkies and giving the fix,
Jet-setting sister, living for kicks.

She also obliges with her euphonium, which is a delightful surprise, and so useful on a night round. Hoss and Mormon discover the Big Brother television screen and resourceful use of a sigmoidoscope reveals added information about its inner workings ("very capacious"). Runt and Bounce launch the linen basket containing Sister Yaws into outer-space by balloon. Runt and the tone deaf Bounce sing.

RUNT'S RECITATIVE, BOUNCE'S BALLAD.

Bounce :

Tone deafness and an abrasive disregard for scansion
Have left us without a song but plenty of room for expansion.
I am the twin-coil, counter-rotating, disposable Bounce,
Hopping around in the background, ready to pounce.
My naked and burning ambition but scantily clad,
By the softest of soft collars and a manner suggestively mad.
The literary third man of the conveniently destructible book,
King of the kidneys and of experiments the cook.

Runt :

Widely known as the earliest rising Professor of Physiology at Guy's,
I feel I have to lay a few canards and quash a few lies.
My way of life rests squarely on gastric secretion,
And if I cry Wolf (and Wolff) it's through a sense of repetition.
Whipping out my twelve-inch, rubber, red, flexible Ryle's,
I stuff it up the noses of anything from headache to piles.
It only shows that the intestinal juices,
Have professorial as well as gastronomic uses.

Chorus :

Maybe our hands are
Stained, but our sands are
Running out fast now.
Cruel to the last now,
We are the Gods here,
Fixing the odds here,
Not giddy at the top,
Despite the drop.

Bounce:

Champagne Bounce! With the '65 vintage face;
Quiet genius of this or indeed any other place,
Unlike the General, I did not quite turn sour,
From scrubbing out the dirty corridors of power,
Consultant's consultant : wise head on youthful shoulders,
Respectfully listening not to my betters . . . just to my olders.
The toast of Sevenoaks . . . a fellow full of knowledge,
Full-time consultant and likely lad in the College.

Runt:

Admittedly I haven't the hordes of women that other professor
Crams the second floor with as modified father confessor.
But a large department is merely an additional onus,
Whilst an Aston-Martin, bird-wise is some symbolistic bonus.
My taste in food is sybaritic but refined,
I eat well with the registrars and though watered, not wined,
As I drop my chicken and ham paté down the Magentrasse,
I feel it's the Guy's equivalent to Mousse de foie gras en Brioche à la Montparnasse.

Groiner sickening of his impersonation, discards his wig. He is discovered by Mormon, who is distressed enough by the deception, but even more so at the thought of Sister Yaws being somewhere over the Irish Sea. They both agree that the Professor must be stopped before he really gets out of hand.

The next scene of activity is a corner of William Gull. Battlefield and his boys have brought Functioner to see a very disturbed and un-co-operative Sir Evelyn; after a characteristic examination he concludes "back home we'd call him mad", and Sir Evelyn is on his way to the Maudsley. The unfortunate patient in the next bed is at first assaulted by Hoss and Smeared, and later castigated by Groiner for his obesity, as well as his family, dog, cat and budgerigar. Groiner also gives an ominous warning to the exuberant Battlefield, who now feels nothing can stop him (" next No. 10 and, who knows, President of the M.C.C.")

The final scene is the Committee Room. They are all there, with Dalek in the Chair. Battlefield is the new Minister of Health in the Liberal Government. He can now wear his wedding clothes every day of the year and announces screening of the entire population in a National network of enforced Diabetic Concentration Clinics. He leaves with his boys, as he is due at Buck House with Will Mann. The opposition is not to be defeated. Spawn, at Groiner's instigation, is going to try and rustle up some spirit from the past to help them. He is successful. It is Thomas Guy who materialises in Mormon's body.

THOMAS GUY'S SONG

(*Jolly*)

My life and times were tough and crude,
The people prayed for milk and honey,
Yet faith was strong, spite customs lewd.
Dear God, religion brought me money :
My cut-price Bibles were preferred,
Good hard cash for the Holy Word.

Chorus :

I've seen 'em come, I've seen 'em go,
Bright and Hodgkin, Hurst and Bo.
So be careful what you do,
I'm watching you . . . I'm watching you.

I dished out money all my life
And now I reap eternally;
For though it couldn't land a wife,
It stopped me going infernally.
I lost my life and found instead: one
Lives a gay life (though a dead one).

The nineteen sixties, filled with gloom
My clear but melancholy head,
Until I saw in Wilks's room
There stood a Royal Shamm instead.
I rest in Peace, I would be silly
To cavill at our nobly Willy.

Battlefield, Bounce and Runt have been intercepted by Sister Kix and Polly, and the testy Guy banishes them to the Isle of Dogs. They make a quick get-away in the Aston Martin, heading for the rusty side of the Iron Curtain. They have scared easily, for it was really only Mormon pretending to be Thomas Guy. Well done, Jolly, he has saved the hospital. And so the final chorus, and the end.

Christopher Mallinson is to be congratulated, not only on the construction of the play and the script, but also on the introduction of new characters. The chronic sufferers of Residents' mimicry had a rest this year. Gerry Spawn, Jolly Mormon, Mandy Smeared and Charles Groiner were all well taken off, and the latter two particularly so. The two professors, John Runt and John Battlefield, were also well portrayed, but Sam Hoss and John Bounce were surely the originals. Hoss, with his basic approach and trenchant remarks, and the lively, uncomplicated, but wise Bounce will both be remembered as classic roles. It was that happy combination of appearance, voice and characterisation together with a suitable script. Scurry Functioner did not look too much like the original, but made up for this by superb mimicry. He was our man all right. The voice and actions were perfect and once again the script was important. The playing of minor roles all achieved the standards expected, such as Sister Kix, Sir Evelyn Tension and the patient. The love affair produced a rather bizarre association. The hero was effective in his monstrous way, but not a sympathetic character. Polly Arteritis, however, was a perfect darling. This performance was quite outstanding and showed real talent.

The music was gay and tuneful, but the song writers were handicapped this year by a rather croaky lot of Residents. In the production, a new feature was the elevation of the stage by five feet. It must have presented many problems, such as scene changing, but I think there can be no doubt that the stage settings, visibility and acoustics were greatly improved by this arrangement. Knowing the labour involved in producing the Play, the producers did a good job, which cannot have been made easier by being Residents themselves. However, as in past years, they have been greatly helped by the Guy's Theatre Club, which does much to ease their burden and to maintain the high standards of production.

I think the make-up should come in for special mention this year. If it is bad, it can wreck the Play, and too often in the past exaggerated make-up has made the characters look grotesque rather than life-like. This year the make-up was particularly good and one was hardly aware of it—the highest praise possible.

I liked this play. I enjoyed the first act especially. The second act dragged a little for me, particularly when the plot was being resolved in the final scene. It is always a problem for the author to avoid a final scene becoming tedious with lengthy explanations, with the cast getting out of character, and all this occurring at a late hour. In common with most plays in the past, this play was too long, and would have been better for being about one scene shorter. However, this is not a damning criticism, and I cannot be responsible for the Play being withdrawn after a week, or for preventing the Residents from touring the provinces. This is the life span of the Residents' Play and we shall have to wait until next February before we welcome this group of players again. We hope they maintain the high standard seen in "1965."

G.W.S.

THE CAST (*in order of appearance*)

THE MODS..
The Misses P. Banks, J. A. S. Carruth, G. T. Klauber, P. MacAndrew

Mr. MANDY SMEARED ..... I. M. Boyd
Mr. SAM HOSS ..... R. L. Strickland
BIG BROTHER ..... J. R. Hockey
Miss POLLY ARTERITIS ..... D. K. C. Cooper
Mr. SCURRY FUNCTIONER ..... T. J. B. Harris
Dr. JOLLY MORMON ..... J. R. W. Keates
Prof. J. BATTLEFIELD ..... W. G. Reeves
READER J. BOUNCE ..... M. N. Maisey
OLD MEN .. M. J. Wright, H. D. Tunstall-Pedoe
Prof. J. RUNT ..... R. Gilkes
Dr. CHARLES GROINER .... R. H. S. Mindham
Miss MORE LIGHT ..... M. J. Wright
Sir EVELYN TENSION ..... J. A. S. Carruth
Dr. GERALD SPAWN ..... T. C. Davis
Mr. APE EARIENT ..... A. E. Davis
SISTER KIX ..... R. J. Parker
FAT STUFF ..... B. S. Worthington

AND ASSISTING BUILDING, PAINTING, ETC.

J. Brammer
M. Carter
A. E. Davis
J. Robinson, M. Pearce, N. Thompson
N. Watson, J. Brammer
A. J. Knell
C. G. E. Gladstone, J. E. Husband, S. H. Marshall
M. J. Wallace, G. McCarthy
P. K. D. Bush
H. D. Tunstall Pedoe
Hilary Scott, Ann Evans and J. C. Gazet

Produced by I. VADASZ and T. C. DAVIS.

Words and Music by
A. E. DAVIS, I. D. B. RENNIE, S. R. MEADOW K. M. PAGLIERO, P. E. INWARD.

The Play by
CHRISTOPHER MALLINSON.

A record of the songs and music of this year's Residents' Play may be purchased as usual. The recording will be of a higher quality than usual, and is available at the reduced price of £1 1s. 0d. for a 12-inch long playing record. Please send applications to C. P. W. Warren or the President of the Residents, East Wing, Guy's Hospital.

HOSPITAL INFORMATION

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Junior Medical Registrar,** with duties to commence on 29th April, 1965, for appointment until 30th September, 1965, in the first instance. Application forms are obtainable from, and should be returned to, the Superintendent, Guy's Hospital, London, S.E.1, not later than **31st March, 1965.**

PERSONAL

Guy's man selling, for health reasons, Dental Practice: large county town, W. Australia. Wonderful opportunity. Details from Mr. Goodliffe, Medical School.

GUY'S HOSPITAL GAZETTE

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EDITORS B. H. HICKS AND P. BOWDEN

SPORTS CORRESPONDENT A. PROCTER

GUY'S HOSPITAL, LONDON

PASSIM

Black and White

Somehow the word Negro, like the word Jew, brings to mind ideas which are, for the most part, not of our own experience but hearsay. Both conjure up innate judgment. It is almost as if we had been told Fairy Stories in which they were the bogymen. They react to us and we to them. They are too well mannered, too polite and often too arrogant. We make excuses for them, protect them or enslave, they often go out of their way to be upstanding so that we may have nothing to hold against them. We are more fair to them than we are to our own people so that we may not be accused of bigotry. The whole relationship must be conducted delicately so that neither's toes are trodden on. They treat us and we treat them as a sane person reciting platitudes to the insane. Our attitude is that of a respectable gentleman viewing his spotty adolescent son who has long hair, tight trousers and loves the Stones. We know that after this period of unrest he will become an asset to society.

When the Belgians left the Congo they had not trained any native of that country to hold a responsible job. They had no service officers, lawyers, doctors, priests or police of their own clan, no one to lead them. Many European countries have bled Africa, and in so doing, have advanced their own land, and they have used native manpower and raw materials with little advantage to the "donor". A century or so later they built a few hospitals and schools and left with the dictum, rule yourself. We are asked now to sustain as we have been sustained but our moral obligation is more apparent although more difficult to fulfill. Morality is an active thing, an inescapable effort, not political but humanistic, our intractable responsibility.

There is little doubt that much of Europe is built with the sweat of Africa, to-day the exploitation is better disguised but it still exists. We owe a lot to these people and our debt must not be paid with ingratiating kindness but thankfully. We have still to learn that we are condemned by the pretexts by which we have judged others.

Some months ago a *Gazette* article on "Roman Southwark" suggested that the excavations for the Tower Block might well disclose more relics of interest. Last week, however, we were vaguely alarmed to read of "basements overflowing" with bones and ancient relics, and of the Roman boat dug in 1910 which is still in storage. If digging at Guy's turns up anything of value the day might dawn when *Passim* calls for an extension to the Gordon Museum, and large, wooden long-boats squeeze themselves between wax-models and sad specimens. As the just completed "History of Medicine" lectures sought to remind us, past patterns in thinking—in and around medicine—are not so irrelevant to the present. Dr. Moynahan stretched

relevance to its breaking point when, in one splendid sweep, he ascribed the entomological title of those "long-haired, sphincter-relaxing youths" to the derivation of the maniacal *tarantella* of southern Italy from the name of the spider *Tarantula,* whose bite was believed to be responsible for the entire condition. No explanation was offered for modern dancing manias, though we suspected that Dr. Moynahan could have concocted some fairly effective treatments, given a free hand. And, in fairness, the guitar is a descendant of the philosopher's lyre . . . it just seems to be mixing in poorer company.

A small but heartening tribute to one department of the hospital was contained in a recent letter to the *Daily Express.* A mother told how her five-year-old son was actually looking forward to having this operation, rather than being terrified. The four-page introductory comic, the all- day visiting, and the friendly atmosphere, are obviously doing their stuff!

And, at last . . .

FROM OUR PARLIAMENTARY CORRESPONDENT

". . . Following the Gillie Report, in October last year, the Ministry and the profession set up under Professor Butterfield at Guy's Hospital a general practice research unit. I want to quote words which appear in an article written by Dr. Robert Smith, who is now head of the unit, which appears in the Guy's Hospital Gazette : *The future of general practice cannot be planned in isolation. Tripartite medicine belongs to the past and has little place in the future health arrangements of new developing areas.* With this categoric statement that tripartite medicine belongs to the past, I find myself in complete agreement. . . ."

Parliamentary Debates (Hansard). House of Commons Official Report. Tuesday, 16th March, 1965.

GUY'S DIARY

APRIL.

EXHIBITION.		*Haematemesis.*
5th M.	1.00	Dr. BAKER. Clinical Lecture. *Uncommon causes of Heart Disease.*
6th T.	1.00	Mr. BLACKBURN. Clinical Lecture. *Obstructive Jaundice.*
8th Th.	5.00	*Neurosurgical Round:* Conducted by Mr. Murray Falconer. Clinical Theatre.
10th S.	10.00	*Departmental Round:* Conducted by Mr. Ian Todd of St. Bartholomew's Hospital. Clinical Theatre.
13th T.	1.00	Mr. ECKHOFF. Clinical Lecture.

The Medical Curriculum

W. J. H. BUTTERFIELD

PROFESSOR OF MEDICINE

The Gazette is 2,001 numbers old. A sort of Methuselah—congratulations to all the surviving Editors wherever they may be and many happy returns to the most widely read medical school publication.

The Welfare State, by contrast, is in its adolescence and judging from the reports it is getting, particularly those germane to the medical curriculum—Robbins on Education, Porritt on the Health Services and Gillie on General Practice—it is a turbulent adolescence at that.

The difference between the *Gazette*'s serene and happy event and the rapidity of the changes in contemporary society represents the varying challenge we have to meet and overcome in thinking about the medical curriculum.

Our Future

The particular challenge at Guy's is this. We stand as the inheritors of a Golden Age about a century ago, but we have got to find out quickly what is best in the traditions this has bred and use it as the basis for meeting the future. It has never been easy for the generations succeeding great men such as we respect at Guy's. One draws the envy of some, the contempt of others, both of which can influence our decisions in subtle ways, making the stubborn more stubborn and the radical, revolutionary. And when all about us is upheaval, the natural reaction is to hold on to the tried and true, to play for time, to wait and see. And there is a strong feeling that if we change, how can we hope to match the accomplishments of the past? But one senses from the conversations one has on stairways, from the tenor of committee meetings and from the feeling in the air that there will be changes. Those in authority at the G.M.C. and at Guy's felt the tide turn some time ago: the G.M.C. recommended experiments, and discussions are about to begin at Guy's. All one can do here is to try to review the situation and write out a few principles—a few of Professor Hunt's celebrated pegs—on which to hang our decisions and then try to make some plans to stimulate discussion.

The Guy's discussions are going to take place against a very complex background—with three major aspects—the National Health Service, the education of doctors and the particular problems at Guy's. And since one feels that form follows function it is perhaps worthwhile considering the broad matters first and inter-relating them.

The medical profession and medical schools no longer exist as individuals. Society is too complex, the division of labour too far advanced for us to proceed simply to educate men and women who believe they can heal unaided by many other supporting groups. Politics and economics have produced a National Health Service which means literally an organisation which by healing restores the nation. Our new curriculum must take account of this. Guy's men must be doctors who enjoy their work because they feel their responsibilities in the National Health Service match their talents and aptitudes, who so enjoy their work that they want to contribute to the integrated services, who can and therefore do select whom they can heal personally, rationally and unemotionally, and so get the satisfaction of restoring health; but their thinking must also include those whom they, or the profession as a whole, cannot heal—whether they be spastics or phenylketonurics.

The big problem in this is defining the present state of health of the nation, and planning what we are going to do about it when we know. Here the only principle one can hold is rational action: our primary need is for operational research to give more information. The Bermondsey and Southwark Health Survey which we have been carrying out under a grant from the King's Fund is an example of this sort of study. What it shows is that many people have symptoms and take no action about them, and of those that do take action only a small proportion go to their doctor. So our national statistics really reflect only that part of the nation's chronic sickness (this does not apply to febrile or acute severe illnesses) which the patients bring to the doctor—which depends on the accessibility of the doctor compared to the chemist. Considerations like these explain the large amount of unrecognised chronic illness, e.g. anaemia, diabetes, etc., which is found in epidemiological surveys like Bedford. Our current estimates are that there are six times as many symptoms suffered as are brought to the doctors.

Already G.Ps. have an average of 200 symptom-decisions a week; they cannot deal with more and live an enjoyable life, or do a good job selecting whom they can heal. We shall therefore either need more doctors, or more people to help them, as a more affluent population takes advantage of their weekly contributions to the N.H.S. Either way will affect the scene at Guy's—more students, or more guidance for students in managing ancillary services. Furthermore, Guy's would do well to take its responsibility in training the new services—our famous dental, nursing and physiotherapy schools are only the forerunners in this matter.

I hope I have managed to convey to my readers that this aspect of the challenge is immense, fascinating and worthy of much more investigation: the importance of our efforts to plan integrated medical care at Greenwich and Erith and the effects of this exercise on our appreciation and thinking about the curriculum will become increasingly apparent over the next few years. But what this is all going to

show is that we must teach students about management, selection of cases to treat and delegation of responsibilities. It also means they must know more about sociology, epidemiology and social medicine.

Medical Education – expanding knowledge - More time needed

The educational scene is equally confusing. New knowledge is being won in research laboratories, new techniques are being applied to medicine, the literature is growing rapidly to enormous proportions. All this is happening much faster than it can be assimilated. Furthermore, some old beliefs and clinical notions are being swept aside by the new information and replaced by new ideas. Will these prove any more reliable? How long before today's certainty passes into limbo too? This is very disturbing to many students, but it should not be. There are and always will be shifting sands in medicine and the doctor must learn to accept this just as everyone else does. The important points are that we teachers must all make careful and accurate measurements in our chosen field of work and students must come to appreciate and demand accurate measurements and reliable data. He should be made aware that our inferences are often in error and he should be brought to recognise, and one hopes enjoy, the intellectual pleasure of a new inference, especially one confirmed by a fresh measurement, whether in a laboratory, or a new treatment for a disease, or a new diagnosis for an old complaint.

What does all this lead to? Are we within sight of a synthesis, a bringing together, of all this new knowledge? Some have hoped that the unification of the ideas behind DNA and proteins may help—but one has great doubts. This simplification will only partly compensate for the complexities wrought by developments in epidemiology, social medicine, pharmacology and therapeutics. The situation which the student must face is simply this: whereas there is only about one doctor per 1,000 people, some 4 per cent of the national budget is spent on health and welfare. Many of the other people involved are extremely able and make valuable contributions, and the student must be made aware of their activities if he or she is to use their contributions properly in his healing activities. The only conclusion one can reach logically is that it will need longer to encompass all this knowledge, to reach the mature personal judgments which typify the good, well-balanced doctor. Longer, I suggest, than the current $4\frac{1}{2}$ years between school and finals for many Guy's students. Personally, I think it will take nearer 6 years.

Integrated teaching

There is widespread interest about integrated teaching at present. This is by no means a new idea in medicine, particularly at Guy's where Astley Cooper began teaching at the bedside, where most of us realise we have learned much from the cases we have studied and understood best, rather than from the textbooks. But there is also no doubt that the main difficulty here is how few modern cases are textbook cases; our therapy is aiming to prevent this all the time. This is one of the present dilemmas of the teacher, it is almost synonymous in these terms to Heisenberg's "Uncertainty Principle" in Physics.

We know about a certain disease, and that no patient will actually fit perfectly into this description, just as no person is normal—once studied his abnormalities become apparent.

My own feelings about these integrated teaching activities (symposia, topics, etc.) are as follows. Firstly, they require a great deal more planning than people first realise. Properly organised they would demand more teachers. Secondly, because they require more preparation, economy demands that they command large audiences. I am not in favour of compulsory lectures, nor am I interested in getting rid of lectures completely. In general, they should be optional. I feel they should be good enough to steer and stimulate the student over the subject or bring together various aspects of a subject. When the subject is too diverse for a single person, or too long for a single person to hold the audience's attention, lectures must be replaced by joint presentations. Whenever this can, or does, integrate pre-clinical, para-clinical and clinical disciples, integrated teaching is in progress.

What one might envisage at Guy's would be mid-day medical and surgical cases conferences at 1.0 p.m. on two days a week instead of clinical lectures. The first four or five weeks of each appointment would be put on by the staff and registrars of the various firms—a review of the disease, consideration of a case, discussion of him/her in depth—i.e., about the disease, the firmness of the diagnosis, therapy, management in the particular case and the social, occupational and perhaps epidemiological aspects. This should be followed later in the appointment by similar presentations by the students on the firms, and then by similar presentations by special physicians (cardiologists, neurologists, dermatologists, etc.). One would recommend, of course, that since much preparation should be put into these cases, many would attend—this really demands the establishment of a new tradition, but we should not worry. Experience suggests that teachers known to take trouble tend to draw the crowds.

All this should not interfere with the present Combined Medical and Surgical Rounds. Distinguished speakers, combined presentations with pathologists, physiologists and pharmacologists and the active participation of general practitioners and students in the discussions should continue to attract audiences.

As integration goes on, one hopes that symposia will emerge. One on Genetics is in the air, involving many departments. But again, one must be sensible and test the market—it would not be economical to do this unless it were going to attract a reasonable crowd.

Finally, the recently inaugurated lectures in Physiology and Biochemistry and the Tuesday medical film shows all reveal one other important feature, the desire among clinical students to go *back* to the pre-clinical subjects for revision. An answer suggested by Dr. Houston and Professor Hunt is that physiologists, pathologists, anatomists and pharmacologists might be encouraged to take a much larger part in ward rounds. Registrars might organise their consultants' rounds a day in advance and try to give them help in finding the pre- and para-clinical speaker or speakers. There is a strong case for a revision course on pre-clinical subjects available during the

clinical appointments, perhaps in the late summer months (when teaching responsibilities in those departments could be at a low ebb). As Dr. Mahler points out, this is a time when general practice tends to be quieter and such revision courses could form the nucleus of post-graduate teaching at Guy's.

Teachers and Tutors

A little earlier the question of teachers arose. There is no doubt that the pressure upon them will increase. They are already exposed to a very large number of distractions by modern communications; the foreign visitor or research worker, the demand for articles to fill the journals, the committees, the T.V. programmes, courses for G.Ps. and nurses, advice about teaching machines, drugs, computers and so on. In addition, to get the best out of students whose numbers may increase, who will be part of larger audiences attracted to more carefully planned and, one trusts, more stimulating demonstrations, it will be necessary to have a tutorial system, where the individual students, in groups of 2—4, will be able to seek guidance, feel they are not lost or isolated, where they will be asked to prepare material for discussion and hear the arguments for and against, and gossip about, current work and so on. But this can only evolve if there are enough teachers to do it, which will depend upon the grants received from the U.G.C. and on the availability of suitably interested and motivated teachers. Meanwhile, explorations of the available staff being willing to act as tutors, including registrars, lecturers and research workers in clinical subjects, are being carried out by Dr. Bowyer, who finds that there are 110 postgraduates of registrar grade who might be asked to give three students one hour a week.

The Full Life and the Whole Man (or Woman)

The whole question of tutors leads on to the next point—encouraging the development and growth of the whole personality at medical school. Here again, tutorial relationships, similar to apprenticeships in earlier times, could be important. Clearly Guy's, with its diverse student body, must encourage the Arts in its midst and the Quodlibet Society, the Theatre Club, the Music Club and other organisations are all extremely important and the curriculum must leave proper time for these activities as well as physical recreation. A balanced life between study, the arts and physical recreation is what we must encourage, coupled with conditions where the student gets the guidance and the feeling that advice is available about his career and chances. All this is possible and goes on to-day between staff and some students, and should be encouraged and extended.

Obviously, all this needs not only a longer course, but also more staff. And if it is to be feasible in the circumstances of modern London life—with hours lost in commuting, shopping and cooking, etc.—we shall need to give attention to students' living conditions, learning conditions, the opportunity to withdraw to read and to learn E.C.Gs. on teaching machines. My own feeling is that all this is most likely to flower if there is more residential accommodation for students, plans for which have fortunately been put in train by Sir Rowan.

Examinations

Examinations in medicine have two purposes. On the one hand, as a stimulus to learning and to test the students' (and teachers'?) ability, and secondly to permit those who qualify to practise medicine without too much risk for the populus. Because of their awareness of the changes afoot, the G.M.C. has recommended schools to reconsider their methods and experiment in the field of medical education.

Following this the University of London has raised the possibility of internal Final examinations and several medical schools, dissatisfied by the sheer size of the candidate list for the London Final, and believing that the sort of case that tends to come up may be a rather artificial one in terms of modern medicine, have opted to test their own students. This may or may not prove relevant to the present local deliberations. Many of us view with dismay the possibility of the break-up of the University of London Faculty of Medicine which, *en bloc,* is the equal of any anywhere in the world, the envy of the U.S. and U.S.S.R., and a great Mecca for doctors from the developing and emerging nations in all parts of the world. Whatever happens, this overall unit should not be jettisoned without careful regard for the international consequences. Internal examinations in some schools could lead, before long, to the paradox of the Conjoint becoming the proof of adequacy and the place where comparisons between schools may be made—all of which is an interesting thought for those who remember the drive to establish the M.B. as the Blue Ribbon!

What about internal examinations each year, or each term? There is no doubt that the "quiz" is a stimulus, that passing it gives a sense of accomplishment. But alas, we all know that it is soon forgotten. How many men sat up all night memorising formulae or cultural characteristics of bacteria, or some such doggerel, and passed and forgot it all in the alcoholic haze of the ensuing celebrations. And yet we must amass some pegs, the hard facts without which our practice becomes soggy and uncertain. Eventually, I feel sure, the curriculum committee will have to draw up a list of these "pegs" from our teachers, reviewing them every quinquennium, and ensure that they are recognised by the registrars, covered by the demonstrations, lectures and books on the reading lists and known by our candidates for examinations, internal and external. Some of these pegs will be permanent and immovable, others must be kept relevant to clinical practice of the day; for example, more attention must be given to the relation between smoking and lung disease than to recognising the complications of typhus fever. This list will help the organisers of programmes, the integrators of our curriculum—thereby, one hopes, preventing repetition on the one hand and gaps on the other. Such an integration of *teachers* might resolve many of our difficulties. It would be a more valuable operation than discussing the curriculum in terms of personal, individual opinion—like this article! On the other hand, rationalised information, such as the new Student Education Committee may be able to provide, could be all to the good.

Some Particular Features at Guy's

There are some other special features about the situation at Guy's which will have to be taken into consideration as the curriculum is hammered out. Quite apart from our estimates of the future of the Health Service, of general practice, of electron microscopy and so on, we must face the fact that the local population is declining: where 300,000 persons lived before only 100,000 persons will live in the future. Such are the effects of World War II and the L.C.C. slum clearance and rehousing schemes. We have therefore needed to think seriously about the source of our clinical material which, as the recent study of out-patients under the King's Fund grant shows, depends largely on Bermondsey, London Bridge commuters and Guy's men further out in the region. Means must be found to increase the students' experience of medicine in the district, vanished now with the disappearance of domiciliary obstetrics. This will come if nearby regional hospitals are involved in the Guy's teaching programme, as already obtains for several medical firms whose clerks go to Lewisham, Plumstead and the Miller Hospitals for two week periods of residence. But all the evidence is that the local population will age further, and statistics show that older persons have to stay longer in hospital—many of my readers will be all too conscious of the geriatic problem which exists at the moment.

Ways and means for students to help solve their own problem are being explored. Letters have gone out to local firms of G.Ps. to see if they would be willing to form, in turn, associations with Guy's firms, with students helping as the link men. So far there has been no definite response, but I believe it will come when the standard of living in many Bermondsey homes, especially those with telephones, will permit the much earlier discharge of some peptic ulcer cases and mild coronaries, with students acting as externs for follow-up. But it will have to go further than that. Geriatrics is obviously a main and urgent problem of the Welfare State—it is estimated that 95 per cent of the facilities for persons over 65 are used by 5 per cent of the same age groups, so a serious situation will shortly arise when the other 95 per cent start demanding "their rights". I believe that students, acting as externs, may have an important role to play in getting acquainted with, and thereby solving, this whole problem.

Another important point which will arise is related to the rebuilding of Guy's, and, before long one supposes, the Medical School. Of course, a case can be made for taking the preclinical subjects away from the hospital site, but on reflection I for one am currently opposed to this, largely because I feel that to integrate our teaching all must stay together: communications are bad enough without more physical separation. Furthermore, operational research on the state of health of the nation, to-day and in fifty years, will leave so many uncertainties that we would be better advised to keep together: one never knows when biochemistry, biophysics or biology may not suddenly become an essential part of bedside teaching. Since ministerial plans contemplate a Guy's Hospital being rebuilt at London Bridge, I feel that our whole medical school must stay here too.

The Curriculum Proposed

In the foregoing, various points have arisen, many from discussions with colleagues, some from research with colleagues. There have been many platitudes. The following curriculum which I offer for discussion is, therefore, the blend of many conversations and I make no claim for it being my own—it seems to be a synthesis of what is going on generally at Guy's. It is based on the following assumptions and hopes:—

1. The Medical School will stay at Guy's.
2. The additional factors involved in medicine make a longer course obligatory: that is, to compete with top quality products in other countries, medical schools will require $5\frac{1}{2}$ to 6 year courses.
3. Earlier contact with patients is desirable, but
4. Students should take an *increasing* responsibility for their care as they proceed. This means they should have experience first with para-clinical aspects of medical care.
5. Because of individual variations in learning processes (e.g. visual v. auditory memories; patient v. book-based learning, etc.) different sorts of learning opportunity must be available.
6. All students will have a tutor to give them individual guidance about aptitudes, progress, learning opportunities, etc., and perhaps to show them cases from the start of their career.

To overcome the student's sense of being overwhelmed by the growing knowledge, it is intended to give him a sense of direction in thought and learning. This means emphasising the continuous, ramifying and extending streams of thought, with minimal division into either academic years or departments. An example of such a stream or ramification would be chemistry to biochemistry, chemical pathology and therapeutics. Other examples are identified below.

Assuming the main streams of thought developed at school or in our Pre-medical Department were biology, chemistry, physics and mathematics, the first year should proceed to anatomy of the limbs, head and neck, physiology and biochemistry. The second year would see anatomy extend to neurology (a clinical appointment) and histology, going on to embryology in the third year, linking up with genetics and obstetrics. In the third year histology would branch into cell biology on the one hand and morbid anatomy on the other. During the second year, physiology, apart from its natural links with biochemistry, would have ward visits and patient demonstrations, leading in the third year to clinical signs and so to clinical work. Biochemistry would lead into clinical biochemistry and chemical pathology: there seems to be no reason why second-year students should not have duties drawing blood for routine hospital tests, to relieve those who complain about this responsibility later in their course!

Details of the growth of ideas are shown in the table (*overleaf*). With a coloured pencil or two one can quickly trace out the connections between subjects year by year. The main point of such an

Table of suggested curriculum indicating streams and diversification of subjects.

Pre Medical	1	2	3	4	5	6
Chemistry	Biochemistry	Clinical* Biochemistry	Clinical* Pathology Medical			
Physics		Biophysics (Electron-microscope, X-rays etc.)	Genetics*	1st Medicine	2nd Medicine	Clinicals
			Cell Biology			
			Bacteriology			
			Morbid Hist.	1st Surg.	Surgical	2nd Surg.
	Anatomy (limbs, head, and neck)	Histology	Pathology*		Specialties	
		Neurology*				
Biology		Embryology		Obst. and Gyn.	Therapeutics	Medical
			Pharmacology		Anaesthesia	Specialties (Geriatrics,
	Physiology	Clinical* Physiology	Clinical* Signs			Gen. Prac. Special Clinics)
				Paediatrics	Preclinical Revision	
		Psychology	Psychological Medicine*			Elective Period
Maths.		Statistics Sociology	Biostatistics Epidemiology Social Med* Occupational Health			

**Clinical appointment or contact with patients.*

Exams.	Anatomy	Biochemistry Physiology	General Path. Bacteriology Pharmacology	Obstetrics and Gynaecology	Therapeutics	Medicine and Surgery

exercise is that it will show which departments and teachers should be getting together to discuss continuity and integration of their subject matter, the "pegs" and the best means of conveying their ideas (patient, film or diagram, original paper or monograph, etc.). The anatomy of thorax and abdomen would be learned in the postmortem room, and that of the head in the surgical specialities, E.N.T. and Eyes. Important innovations I propose are the introduction of para-clinical subjects and psychology, statistics and sociology (12 lecture-discussions) into the second year, leading to epidemiology, social medicine and occupational health respectively and a clinical appointment in psychological medicine. It is also important to note that by the end of the third year this curriculum covers all the natural groupings of ideas—ranging from molecules (chemical pathology), macromolecules (genetics), cells (cell biology), small organisms (bacteriology), tissues (histology) and diseases (pathology) through drugs and patients to society. Thereafter, the fusion of these ideas with clinical work, learning the proper compromise between wide knowledge and the needs of the individual case, between perfection and practicability, would begin.

Finally, a few words about the $2\frac{1}{2}$-3 years of clinical work. I have included two periods, one for pre-clinical revision, the other elective, for example research, foreign travel, locum G.P. attachments or what the individual student, on advice from his tutor (who will know his card) decides. There are two other innovations. To-day it often happens that people passing Conjoint do appointments as A.H.Ps., and I see no reason why an appointment akin to the old "Clinicals", an A.H.P., should not be included in the M.B. curriculum. Of the 40 beds per medical firm H.P's. would take direct care of fewer beds (16-20) but more out-patient responsibility to follow up their cases, A.H.P's. would have 8-10 beds and final year students, "clinicals", would have 3-4 cases, preferably local people so that they could follow them up at home if early discharge home were possible. Clinicals would be supervised by the Junior Registrar.

The Final Examination would occur every six months. After the first medical appointment there would be the possibility of referral for a second medical appointment or a recommendation to proceed directly to "Clinicals" for the top students. This would indicate to the lazy that they had to do more to qualify.

There are many other points which might be discussed—why one puts anaesthesia so late (because here the student actually has his greatest responsibility!), questions of periods of residence in or near the hospital and so on. Suffice it here to conclude by saying I believe that this curriculum would turn out medical men and women with a breadth of understanding the equal of any anywhere, and the best of these would be among the best anywhere.

Table opposite: Suggested curriculum, six years plus premedical, indicating streams and diversification of subjects.

A WEEK IN GENERAL PRACTICE

H. D. Tunstall Pedoe

Until recently my ideas of what general practice was like were largely coloured by the correspondence column of the *British Medical Journal* and the content of some of the scraps of paper brought up by patients to Guy's Casualty when I was on Front Surgery duty. Then, through a scheme organised by the Medical School Office, I was given the opportunity to see general practice at first hand, a week's apprenticeship at Emsworth in Hampshire.

I joined a group practice run by seven doctors; four worked in a converted house in the old village of Emsworth and three from a modern surgery, built with the aid of a Ministry loan in Havant, with a branch premises in a Portsmouth overspill municipal housing estate. Occasional surgeries were also held in outlying villages in hired rooms. Emsworth itself boasted a small maternity home and a cottage hospital with a radiologist and clinical pathologist in attendance, which the practice used. My method of seeing things was to accompany one of the doctors around for the day and I spent most of my time with two old Guy's men, Dr. Angus Harris, who was my host, and Dr. Robert Barnard. It being late February I expected life to be hectic, but things were surprisingly quiet and there was a chance to mull over everything I saw. Few patients seemed surprised at someone being with their doctor—I was usually introduced as a visiting doctor from Guy's. This satisfied most of them; some with family connections in medicine said "Oh, how far have you got with your studies?" straight off; others were fearful that it meant that their own doctor was to hand over to someone else.

A typical day with the doctor involved packing the children off to school and a drive to the surgery, reading the morning mail, morning surgery, followed by collecting a list of home visits and making them, with a break for morning coffee with Matron at the hospital. In the afternoon, after lunch at home, there were more visits and perhaps later an evening surgery or an antenatal clinic. By good organisation, good fortune and some financial sacrifice the Emsworth practice had the services of a housekeeper who maintained the surgery and took all telephone messages, relaying the night ones to the doctor on call from their own little telephone exchange. This was very nice, especially for the doctors' wives. There was also a male nurse who gave injections, syringed ears and did a lot of the tedious paper work that went, for example, with vaccination sessions.

Both the surgeries and the visits had their own peculiar interest. The surgery presented a novel challenge to me. Each patient came in and voiced his complaint and the object was then to take a history, examine the relevant system and make a decision on further action and treatment in an average of five minutes, leaving the patient reassured, informed and satisfied. This was no mean feat. I found myself, probably for the first time, looking at the patient in his chair and

trying to sum him up in toto. What was his real motive for coming and how ill was he? It was not so easy to play for time with laboratory tests or see what a consultant would say. With a specialist opinion three weeks, an expensive 'bus ride, a two hour wait and half a day off work away, things looked very different.

Social medicine lectures at Guy's had prepared me for the preponderance of children under five, of old people and gynaecological and obstetric cases in the waiting room but I was struck by the very large number of vague, virtually undiagnosable complaints such as odd pains or giddy spells in patients of all ages where the only treatment seemed to be reassurance and the passage of time. I also met one or two common conditions whose existence is hardly hinted at in medical school and I began wondering how safe it is to read books and derive one's training purely from hospital specialists.

Clinical examination was of necessity limited. Most patients had their chests listened to, many had sore throats to be looked at, the majority of children had their ear-drums examined. Orthopaedic examination of troublesome limbs probably came next with abdominal palpation fairly infrequent. Urinalysis and microscopy was used frequently in each surgery and I saw several urinary infections in my week. Patients for radiography and clinical pathology tests were given appointments to the hospital. Bacteriological specimens were usually taken only if an infection failed to respond to the usual antibiotic. Blood specimens from the antenatal clinic were picked up by a van which delivered sterile syringes.

The antenatal clinic was very stimulating. The procedure was impeccable and a county midwife was in attendance. Because it was their local doctor the expectant mothers were more relaxed, spontaneous and forthright about their worries than those in a hospital clinic. Dr. Harris was meticulous about preventing varicose veins, possibly because as a general practitioner he was so conscious of their importance. I was struck by the tremendous relationship that existed between the G.P. obstetrician and the mothers, and children he had delivered in the local maternity home or in their houses, and the fund of confidence and goodwill he had to draw on. However when one visited the charming little maternity home one could not help wondering what its future was, inevitably in a small place the midwives were either overworked or unemployed. Forceps deliveries were done under general anaesthesia without a cuffed endotracheal tube. None of the partners at that time had been trained in pudendal block technique and it was difficult for them to make time to go and learn. The same was true of the cottage hospital which provided a superb local service to the community.

Back in the surgery, children made a cheerful contrast with those in hospital clinics. I did not see one cry or whimper, even when having inoculations. I was intrigued to see how closely the degree of follow up and supervision of cases was pitched to the intelligence and ability of the parents. The same was true in home visits. I had always felt that one knew the patients better in Guy's outpatients than on the wards because one saw them in clothes rather than pyjamas. General practice went one stage further. I found the inside of people's houses

and the way they furnished and decorated them and grouped their possessions about them as interesting as their diseases. The contrasts were fascinating—the sick working class child lying fully dressed, wrapped in a blanket on the sofa in the living room, before a coal fire with her brothers and sisters toddling round her—and the genteel little girl with viral pneumonia lying majestically in a huge four poster with her great uncle's naval portrait on the wall. Two other patients stick in my memory. One was an old boy who had been in congestive heart failure for years, necessitating a burst of spironolactone periodically, when his oedema became refractory; he was one of the most cheerful people, pottering about his house, that I have met. The other was a woman who had had a bungled cholecystectomy and unsuccessful repairs of her common duct, and was condemned to recurrent bouts of pain, fever, jaundice and misery, a severe test of a general practitioner's skill.

I did not go to Hampshire to see interesting diseases but this did not stop me from consolidating my repertoire. Even the diseases one saw in hospital created new and interesting problems when managed at home. I saw herpes zoster and post-herpetic neuralgia for the first time. I also saw atypical whooping cough, and sarcomatosis from a Paget's tibia gone nasty, a mitral stenotic with a hemiplegia and a big blue, breathless man with an idiopathic pulmonary fibrosis and gross cor pulmonale who lived at home with an oxygen cylinder. The practice had several cases of thalidomide peripheral neuritis and has sent up patients with other drug reactions such as a Parstelin subarachnoid haemorrhage before they were generally recognised.

Apart from clinics and home visits, regular calls were made at old people's homes. One or two of these gave me the creeps but I was able to visit a new Hampshire County Council building which was beautifully built and administered. Several hundred more of these would solve a great many general practitioners' problems. Old people and their illnesses created situations that demanded a lot of tact in their management. I remember vividly one independent old man who managed alone, fell ill and stopped caring for himself, and was finally persuaded to let his daughter in to clear up. (She fussed around saying, "What a disgrace!" innumerable times.) Also the magnificent old lady whose children were pushing (perhaps a bit too hard) for control of her affairs who after a perfect exchange of tea-time pleasantries confided in us about the voices coming through the air that were telling her to do peculiar things. It seemed to me that finding accommodation for old people who could no longer care for themselves and finding hospital maternity beds for women who needed them were two of the most frustrating jobs that the general practitioner had to do.

The week of general practice was a great experience for me. It was a joy to be thinking and talking medicine in such pleasant surroundings, to see good general practice and how well it was appreciated by the patients. I shall also treasure the memory of my host. Whether it was emptying out and discussing the contents of his black bag over a glass of whiskey, going round his practice, or persuading me to play darts for his sailing club in an evening social, he gave me a fine introduction to the life of a general practitioner.

AN APPRECIATION — *Sister Falwasser*

Sister Falwasser's retirement at the end of February marks the end of a long association with Guy's. More commonly known as Sister Job, she has been a familiar figure to many Guy's men and women and nurses.

Sister Falwasser embodied the finest and most worthy characteristics of a surgical ward sister. An excellent practical nurse herself she was extremely successful in conveying both the practice and the essential sympathy of nursing to generations of Guy's nurses in training. Many Guy's men have benefited personally from her care as patients in Job. She stands as a figure typical of the highest standard of nursing in all its aspects. Many Guy's House Officers will remember with deep gratitude the thoughtful guidance and assistance they received from her while working in her ward. Members of the Surgical Staff who have been associated with her feel an equal debt of gratitude.

Sister Job entered Guy's as a probationer in April 1925, and remained at the hospital for the whole of her nursing career. In September 1931 she became Sister in the Nurses' Home and a year later she took charge of Job Ward. This was in Old Guy's House and the transfer to New Guy's House in 1961 meant many changes to those who had worked so long in the old block, and it was especially valuable that senior nursing staff such as Sister Job were able to assist in the transfer. It gave great joy to her many friends and admirers when her contributions to nursing were recognised by the Queen in June 1959 by the conferment of an M.B.E.

Sister Falwasser was possessed of a firm, resolute nature in all matters affecting the comfort and welfare of her patients but was much more retiring, and indeed diffident, in her relations with others. Hence her unwillingness to agree to any formal or public acknowledgement of her retirement. At their meeting on March 1st, the Board of Governors presented her with an illuminated address expressing their gratitude for and acknowledgement of her forty years of service to nursing and to Guy's. On 2nd February, exactly forty years to the day after she first came to Guy's, a few of her friends were privileged to entertain her at a small dinner at the Royal College of Surgeons arranged by the President and Lady Brock and attended by the Superintendent and Mrs. Blaikley, the Dean and Lady Boland and the President of the Medical Committee and Mrs. Cann, and Matron. Many would like to know that her retirement was marked by these two modest occasions.

Sister Job has retired to Winchester, where she will carry the best wishes of all the many friends among doctors, nurses and patients who knew her during her long and splendid service to Guy's.

"Spinal Injuries"

The Physical Society has arranged a unique opportunity of seeing at first hand the treatment of this disease of the motor car age. A coach will leave Guy's at 12.30 p.m. on Thursday, 15th April, for Stoke Mandeville Hospital, Bucks. Names should be added to list in the East Wing.

One Way Pendulum

Theatre Club Production — March 1965

Though the title of N. F. Simpson's play gives a clear directive, the play itself shows a marked lack of direction. The characters drift along their separate ways—or simply sit around and hope—like Aunt Mildred. But she only hopes for a tricycle to ride into the general drift. This diversity makes production difficult. Does one attempt to create a unity from its divergent parts—to impose a plan and extricate a message? Or does one allow each member of the audience to bind the parts together as best he can?

Above Andrew Seal

Below: Anthony Stoll
David Richards
John Froude
Mary Cunningham

In his production for the Theatre Club, Richard Sudworth clearly chose the latter course. He announces this in his programme note, and sticks to it. "During the performance, the audience may notice that certain parts become detached from the whole. No effort should be made, however, to nudge them back into place—it is unnecessary. They will eventually drop off, and are quite harmless." The play is thus forced to stand on its own one way pendulum, the cast free to grab it as it swings, dodge it, or be bowled over by it. And some were.

This approach had its drawbacks in the first act which is a conglomeration of largely unrelated parts. But in the second act, where the court scenes give a unity and shape, the production had its greatest strength. Here every detail was obviously carefully planned and it was in this act, too, that the cast triumphed over the difficulties inherent in the script.

Presiding over the whole play in his role of the Judge, and clearly in command of the whole, nebulous situation was Andrew Seal. His judgment was considered, his sentences just . . . In a performance of considerable talent, Mr. Seal displayed an

admirable control of timing, fluency of gesture and sense of theatre. He was ably assisted in the court scenes by the rest of the cast. In particular the characterisation of the two counsels, well conceived and consistently achieved, was another of the strong points of the production. Anthony Stoll, as the Prosecuting Counsel, admirably caricatured the legal mind: his playing was crisp, dry, incisive and his long interrogation speeches never flagged in pace or interest. As a foil to the prosecution's precision the defence dithered and bothered. David Richards was well in control of this part, defensive to degree, without overplaying. It was during these scenes, too, that the minor characters shone: the Clerk of the Court (Edward Humphrey) hopelessly making copious notes as he floundered in the proceedings, the Usher (John Hunt) listlessly gazing into space and chewing his gums.

Of the other performers the most successful was John Froude in the difficult part of Robert Barnes. The script calls for Barnes to coax the audience into the improbable Groomkirby household, and then to vacillate between MC and bit-player. Mr. Froude performed his various roles with great charm. John Storrs, as Arthur Groomkirby, was relaxed and confident; Alison as his wife, improved considerably in the second act. Myra Gantry (Cleone Davis) ate her ham roll without relish, while the young couple, Sylvia and Stanley (Christine Cocks and Russell Cowan), were continually at odds, both with each other and with their parts. Miss Cocks had only one tone—shrill; and one gesture—a sort of foot-shuffle. And frankly she needn't have worried about the length of her arms. Mr. Cowan compromised between fallen matinee idol and a clay-footed theatricality.

For the rest, especially in the special effects, this production was excellent. The lighting conveyed the transition from living-room to Albert Hall, the sound effects were splendid; and I must admit a sneaking admiration for the flashing, benign face of old Gormless as he struggled to sing the Hallelujah chorus.

JEAN H. MORTON

Dr. Jean Morton, who died in Guy's in February, was Consultant Venereologist at Guy's from 1947 until ill-health forced her resignation in 1962. Dr. Morton, a graduate of St. Andrew's University, had held posts in venereology in Birmingham, and during World War II held senior posts in the R.A.F. By many Guy's graduates she will be well remembered not only for her clinical acumen and clear teaching ability, but also for her insistence on the importance of manners, dress and deportment for her students as future doctors. Dr. Morton was an admirable fighter for all that she considered right whether for patient, nurse or student. No colleague could have been more generously co-operative or stimulating. The Guy's Art Society owes much to her unflagging interest. Her courage during her final painful illness, of which she well knew the result, was an outstanding example of fortitude.

Student Education Committee

The Student Education Committee mentioned in a previous *Gazette* was elected on Friday, the 18th, and consists of the following persons:—

A. Stoll	1st M.B.
J. Soul M. Gaine	1st year 2nd M.B.
C. Hudson W. Hughes	2nd year 2nd M.B
J. Tripp	B.Sc. year.
R. Lane, *Hon. Sec.* J. Stephens	1st year Clinical.
M. Cunningham A. Raynes H. Sturzaker, *Chairman* S. Kramer P. Ransley G. Machin	2nd and 3rd year Clinical.

At the first meeting of this committee the constitution was agreed upon and is as follows:—

AIMS

The aims of the committee shall be to discuss any matter appertaining to medical education and present the views of Guy's medical students to the Dean, his deputy or the heads of departments as and when required; also to maintain a liaison with the B.M.S.A. Education Officer.

MEMBERSHIP

The Committee shall consist of:—

One representative from the 1st M.B. course.

Two representatives from each of the 2nd M.B. years.

One representative from those doing B.Sc. or diploma courses.

Two representatives from the first clinical year.

Three representatives from each of the 2nd and 3rd clinical years.

Also the Presidents of the Students' Club, the Pupils' Physical Society, and the Secretary of the Physiological Society, or their deputies, shall be *ex officio* members of the committee.

OFFICERS

The officers shall be a chairman, a secretary and a publicity officer. All shall be elected by the members of the committee from among their own number.

The chairman shall chair all meetings and shall be responsible for the conduct of the committee and its work.

The secretary's function shall be to:—

deputise for the chairman in his absence.

to give notice of all meetings and agendas publicly and to the committee members individually.

keep a record of the minutes of each meeting.

The publicity officer shall publicise (e.g. in *Guy's Hospital Gazette*, on notice boards, etc.) the committee's activities.

ELECTIONS

Election to the committee shall be by ballot before the end of the third week of the Spring Term.

Applications for membership of the committee, proposed and seconded, must be given to the secretary within ten days of the start of the Spring Term, and should be signed by the candidate wishing election.

Students may vote only for the candidates in the same year as themselves.

Voting forms shall be distributed to each medical student at Guy's, who will be allowed as many votes as there are places on the committee for his year, and the voting slip must be signed by the voter.

The tellers shall be the Presidents of the Students' Club, the Pupils' Physical Society and the Physiological Society or their deputies.

MEETINGS

At least one meeting shall be held each term.

Topics for discussion should be written and given to the secretary.

Meetings shall be called at the discretion of the Chairman and Secretary.

A meeting of the committee must be held within seven days of a request for such a meeting if it is backed up by the signatures of 30 students.

Any medical student at Guy's may attend a meeting and shall be allowed full speaking rights. However, only members of the committee shall have the power to vote.

The minutes of the previous meeting shall be read, corrected and signed at the start of each meeting.

Annual Dental Clinical Meeting

The morning of Saturday, March 6th, 1965, dawned bright and crisp and, with the snow still on the ground following the blizzard earlier in the week, the restored Old Guy's House and East Wing looked their noble best as old Guy's men converged on their Alma Mater for the Annual Clinical Meeting. However, inspection of the forecourt, the colonnade with its two commemorative plaques and the new administrative offices did not long delay their arrival at the Dental Department, where a programme of demonstrations, in numbers and quality well up to previous standards, awaited their pleasure.

The demonstrations covered a wide variety of topics ranging from neurophysiological studies of the periodontal structures of dogs, to the essentially practical problems of oral hygiene, denture aesthetics and root canal therapy. The pre-prandial lecture was delivered by Mr. Norman L. Rowe, of the Eastman Dental Hospital and the Plastic and Oral Surgery Unit, Queen Mary's Hospital, Roehampton. The lecture —"Fractures, Accidental, Incidental and Intentional", was well attended and delivered in the immaculate style for which Mr. Rowe is well known. Before Mr. Rowe's lecture an innovation took place, namely, the presentation by Mr. Warner of Certificates of Proficiency to the newly qualified Dental Hygienists.

Lunch followed in the old familiar places which varied from the Staff Common Room, where the usual Clinical Day cold ham and chicken salad was served, to " The George" with its bread and cheese with beer.

The afternoon began with Professor Rushton's traditional lecture, "Cases Referred by Practitioners", and, as usual, the Dental Theatre could have been filled twice over. Most of the demonstrations continued throughout the afternoon, which was concluded with tea, cakes and apples in the new East Wing.

Clinical Day is always a success whatever the weather, and despite the obsolete building in which it is held. This is due not only to the organisers and those putting on demonstrations, but also to that small band of people which includes Mr. B. A. Jones, of the Dental Photographic Department and his assistants, the Medical Illustrators, the Maintenance Engineers and the Administrative Staff, who, year after year, put in a lot of hard work behind the scenes preparing for this day. To them all we owe a word of special thanks.

CORRESPONDENCE

Thoughts on Education

SIR,—While the views of the eminent are always of interest, I think that many recently qualified readers will share my dismay at the appearance of yet another series on medical education. Discussion has been proceeding for years, and surely there is by now enough common ground to contemplate a little action.

I am at present concerned with pre-clinical courses, and the relationship between these and clinical needs is as difficult as its improvement is obscure. A study of the second M.B. results shows that these courses are unrelated even to preclinical needs—a more serious failure here, of understanding. Most students come from a "cram" A-level course directly to the factual (or to them, abstract) world of 2nd M.B., are taught mainly via lectures, and have little chance or encouragement to appreciate the importance of ideas as well as facts. The lecture is agreed to be an inefficient first means of instruction, irrespective of the skill or otherwise of the lecturer, and a tutorial system in the proper sense to be immensely valuable in assisting the student to think for, and then to teach, himself. It seems quite possible in the London hospitals for a student to attend at least the preclinical course without any conception of critical thought—and Medicine is at present a university discipline.

The harrowing part of all this for those who as students were involved in the politics of change is that this theme is generaly accepted to the point of nausea. But in London it is likely to remain in committee for a few more dusty decades. Certainly there are difficulties, notably the very high student/staff ratio—the main bar to a tutorial system in Chemistry and Biochemistry here for the present. However, change will follow if the principle is granted more than lip service: the problem is when?

Yours, etc.,

A. F. WINDER.

Biochemistry and Chemistry Dept.,
The Medical School,
Guy's Hospital, S.E.1.

SIR,—After forty years' experience of medical practice, most of which has been "general", I still feel that the best preparation for general practice is a sound education by experts (i.e. specialists) in the various departments of the vast subject of medicine. This education can reasonably be expected from a good undergraduate teaching hospital. It should be followed by the further education of at least two years' hospital appointments, one of which, if possible, with experience in a casualty department and in contact with the doctors of the district served. If at the end of this time the embryo practitioner is not able to settle quickly and efficiently and with enjoyment into general practice, he should realise that this is not his vocation. He should seek an administrative post or other less arduous and responsible appointment not in the " front line " of medicine. No amount of teaching by a " G.P. Teaching Unit" will ever endow him with what he is intrinsically lacking.

To add to the Medical Schools " G.P. Teaching Units " is only increasing the number of Empire builders and their satellites, who are already absorbing so much of the medical man-power so urgently needed in the practice of medicine all over the country.

It is, of course, important that the main bulk of the Ward and Out-patient undergraduate teaching should be done on good material by real clinicians who have experience of and sympathy for the problems that confront the doctor outside a hospital. I personally have found that the considerable number of young men and women of the right type who have come my way have had no

difficulty in settling quickly into practice. I have been able to learn from them much that is new, and I hope they have learnt a little from me that is old.

Yours, etc.,

G. C. MILLIS.

22a, Belvedere Grove,
Wimbledon, S.W.19

SIR,—I have been most interested in the excellent series of articles on "Thoughts on Education" (Medical). Can we hope now for a similar series to cover the dental field, where the problems of integrating the *education* of the student with a largely practical *training* are obviously many?

Yours, etc.,

H. B. PHILLIPS.

Dental School,
Guy's Hospital, S.E.1.

Certainly you may hope, Mrs. Phillips ! We have the project very much in mind. EDITORS.

Student Education Committee

SIR,—At an election held on March 19th, a Student Education Committee was elected for the first time at Guy's.

At the first meeting of the committee it was decided to immediately assess student opinion on the present methods of clinical education at Guy's. In order to do this we are asking the Gauleitors to assist us and we would be grateful for their co-operation. We shall be sending a communication for their guidance in the near future.

Yours, etc.,

ROBERT LANE (Hon. Sec.).

The Gazette

SIR,—It was a pleasure to join *Passim* in its mirror-gazing in the last issue of the *Gazette*. That is to say, the act was enjoyable, but not so the image we saw, which was sad.

The tradition of Guy's is redoubtable, and it has many fine traditions, not least of these the publication of a students' journal, however much the original terms of reference may have broadened. Yet, as you so rightly hint, the student element can hardly be said to be flourishing.

The reason for this must be sought; it must not be merely commented upon sporadically, as the *Gazette* has been doing, we are told, for 91 of its 93 years—in fact, it was doing this before any other student journals even appeared. If the *Gazette* still prints to interest students as well as its many subscribers, and really wishes to do something about student contributions instead of complaining on their scarcity, a few changes should be considered.

Why, for example, were few articles commissioned from individual students —surely the editors know a few—for the current series on " Thoughts on Education " instead of inferring that students should participate in this of all fields mainly by criticism of the thoughts of their teachers in the form ol letters? If this was indeed the intention at the time it has unfortunately proved barren, this form of participation being shunned by the students. Yet it is possible, nay probable, that many who had contemplated a letter were discouraged in this field as in others by the inherent danger, one is told, of airing one's views in the *Gazette* for fear of the reaction of what the magazine itself referred to as " the Gods". Why not allow the practice of unsigned letters? The editor can demand to know the writer, it is his privilege, but this can remain a secret between them. In any case the editor can choose which letters he is going to print, and his conscience must be accepted by the correspondent. In this way the *Gazette* will rapidly be able to claim its role as mouthpiece for the students, who otherwise maintain a discreet silence on paper while keeping the cafeteria staff overtime as they argue over their cold tea in the afternoon.

Another step that should be taken is the liberation of *Passim* itself. This is after all, merely the contribution of another student, perhaps more informed, but it is the fact that it is a student voice that makes it the more interesting. Censorship by " the Gods " brought six and a half years of suspended animation for the *Gazette*, and even to-day one finds that it is still in practice. Has there been no progress or liberation of thought in 85 years?

This is a country which has always championed freedom of speech, appreciated particularly by those of us who have come from places where this has been denied in one form or another. It has perfected the art, too, of diplomacy. But these two attributes are complementary, the former not suppementary to the latter. *This* should be the concern of the *Gazette*.

Those of us who study at this hospital are proud of the fact. If there is realisation of this by "the Gods", could it not be shown in steps which allow us to feel that we are at least a part of its personnel in ways other than providing transport for specimens from the wards to the pathology laboratories? We wish to give as well as receive—*what motto*? Circuses we have received in the form of the excellent new students club. Perhaps *we* can give some bread.

Yours, etc., D. STEPHEN ROBINS.

Guy's Hospital,
London, S.E.1.

We feel that one of Mr. Robins' points deserves answer here—his suggestion that the Gazette *print unsigned letters. While his motives are entirely the best, we cannot agree with him on his views. The students at Guy's have opinions to offer, usually sensible, usually sincere. We do not believe that expression of those opinions would be held against them by anyone in authority, unless we have seriously misjudged "authority." This is indeed an act of faith, difficult to substantiate, but if a little courage is required, what of it? Courage in students and tolerance of honesty, are the least one might expect from our hospital.*—EDITORS.

Mr. Frank Muir

SIR,—Mr. Frank Muir, Chief Technician to the Cardiac Department, retired on March 31st. His youthful appearance and unimpaired vitality make it difficult to realise that he had by that time completed 53 years of devoted service to the Medical School and Hospital. His countless friends will certainly wish him many years of activity and enjoyment in his well-earned retirement and, I am sure, would welcome the opportunity of expressing their gratitude for his personal help in the past and his devotion to Guy's in a tangible way.

In order that the list of subscribers shall be as large as possible, for this will give him the greatest pleasure, individual subscriptions need not be large, and should be sent to me at the Warden's House. They will be individually acknowledged and subscribers will eventually be informed of the nature of the gift and when, with a list of subscribers, it will be presented to him.

Yours, etc.,

C. G. BAKER.

Guy's Hospital,
London, S.E.1.

"Clinical Symposia"

SIR,—I hope you will not object to my using your columns to put out an appeal on behalf of the Department of Anatomy for any back numbers of Clinical Symposia, a journal which is published four or five times a year by Ciba Pharmaceutical Products. This journal has been circulated gratis to members of the medical profession for about 16 years. It contains an extraordinarily useful collection of diagrams highly useful in the teaching of anatomy, physiology and pathology. This department possesses a few odd copies, but I am most anxious to build up a complete set. If any of your readers have any copies for which they have no further use, these would be most gratefully received in this department.

Yours, etc.,

ROGER WARWICK.

Anatomy Department,
Guy's Hospital Medical School.

GUY'S HOSPITAL—JOHNS HOPKINS FACULTY EXCHANGES

YEAR	GUY'S FACULTY	SPECIALTY	JOHNS HOPKINS FACULTY	SPECIALTY
1947	Sir Charles Symonds	Neurology	Dr. Alfred Blalock*	Surgery
	Mr. Nils Eckhoff	Surgery	Dr. A. McGehee Harvey	Medicine
1948	Dr. Maurice Campbell	Medicine	Dr. John C. Whitehorn	Psychiatry
			Dr. William Rienhoff, Jr.	Surgery
1949	Mr. Hedley Atkins	Surgery	Dr. Joseph L. Lilienthal*	Medicine
			Dr. Marcus M. Ravitch	Surgery
1950	Sir Russell Brock	Thoracic Surgery	Dr. Perrin H. Long	Medicine
	Mr. J. B. Blaikley	Gynaecology/ Obstet.		
	Dr. W. N. Mann	Medicine		
1951	Sir Heneage Ogilvie	Surgery	Dr. John Eager Howard	Medicine
	Mr. Grant Massie*	Surgery	Dr. William W. Scott	Urology
	Dr. Philip R. Evans	Paediatrics		
1952	Dr.. A. C. Hampson	Medicine	Dr. Francis F. Schwentker*	Paediatrics
	Mr. W. D. Doherty	Urology		
1953			Dr. Russell H. Morgan	Radiology
1954	Dr. L. Forman	Dermatology	Dr. Lawson Wilkins*	Paediatrics
	Mr. F. W. Law	Ophthalmology	Dr. Joseph E. Moore*	Medicine
1955	Dr. C. Hardwick	Medicine	Dr. David M. Gould*	Radiology
	Mr. S. H. Wass	Surgery	Dr. Samuel P. Asper, Jr.	Medicine.
1956	Mr. W. S. McConnell	Anaesthesiology	Dr. Gilbert H. Mudge	Pharmacology
	Mr. J. S. Batchelor	Orthopaedic Surgery		
1957	Dr. C. G. Baker	Medicine	Dr. C. Lockard Conley	Medicine
	Mr. R. H. F. Brain	Thoracic Surgery	Dr. A. Edward Maumenee	Ophthalmology
1958	Dr. Ralph Kauutze	Medicine	Dr. Robert A. Robinson	Orthopaedic Surgery
	Mr. Guy Blackburn	Surgery		
1959	Mr. Murray Falconer	Neurosurgery	Dr. John W. Magladery	Neurology
	Dr. M. J. McArdle	Neurology	Dr. A. Earl Walker	Neurosurgery
1960	Dr. Kenneth MacLean	Medicine		
	Mr. Philip Reading	Otolaryngology		
1961	Mr. T. T. Stamm	Orthopaedic Surgery	Dr. Vernon B. Mountcastle	Physiology
	Sir Rowan Boland	Medicine: Dean	Dr. John E. Bordley	Otolaryngolgy
1962	Dr. W. H. H. Merivale	Clinical Pathology	Dr. Albert L. Lehninger	Physiol. Chemistry
	Mr. R. S. Lawrie	Surgery		
	Dr. D. Stafford-Clark	Psychiatry	Dr. Barton Childs	Paediatrics
1963	Mr. F. R. Kilpatrick	Surgery		
	Prof. R. H. S. Thompson	Physiol. Chemistry		
1964	Dr. A. B. Wayte	Radiotherapy	Dr. Warde B. Allan	Medicine
	Mr. Patrick Clarkson	Plastic Surgery		
1965	Prof. G. A. D. Haslewood	Physiol. Chemistry	Dr. Thomas B. Turner	Microbiology: Dean
	Dr. Robert Knox	Bacteriology		

*Deceased

JOHNS HOPKINS MEDICAL STUDENTS TO GUY'S

1955 James M. York
Jerome Kowal
Kurtz B. Stowers
Eng M. Tan

1956 James R. Gantt
Henry Yeager, Jr.
Raymond P. Srsic

1957 Richard B. Whitehead
Donald S. Daniel, Jr.
James A. Wilkerson, III
John M. Freeman

1958 Richard J. Cardines
Lorne K. Garrettson
Gerald R. Plotkin
Francis E. Moore, Jr.

1961 Larry R. Kirkland
Samuel R. Lathan

1962 Philander B. Briscoe, Jr.
Marshall W. Webster, Jr.

1963 M. Stanley Hirsch
James R. Brown

GUY'S REGISTRARS TO JOHNS HOPKINS

1953-54	Dennis C. Deuchar
1956-57	George W. Scott
1957-58	Ieuan E. Evans
1958-59	Maurice H. Lessof
1959-60	Denis A. McGill
1960-61	John R. Trounce
	Andrew B. Richards
1961-62	Brian H. Robinson
1962-63	Robert K. Knight
1963-64	J. Anthony P. Trafford
	Timothy J. H. Clark
1964-65	David A. Lillicrap

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SPORT

Although Guy's have been eliminated from the Rugby, Soccer and Hockey cup competitions, we continue to win the lesser competitions with monotonous regularity. The Fencing Cup has just been won, and the Boxing Cup, which Guy's have failed to win only once since the war, is retained as no other hospital can raise a team to compete with the ever-active club. Guy's won the Junior Rugby Cup when we beat St. Thomas's 6—0 in the final. A. Morris kicked two penalties. The hockey second team drew in the final of the Junior Cup.

Guy's enter the Middlesex Seven-a-Side Competition each year, and sometimes do quite well in the preliminary rounds, but never well enough to get into the finals at Twickenham, mainly because the team practises so little. Guy's have some talented players this season and could field a strong seven that is capable of getting to Twickenham—it would be very welcome indeed to see the blue and gold jerseys playing at the headquarters of rugby football.

In the Hospitals Seven-a-Side at the Bart's ground at Chislehurst, Guy's were knocked out in the semi-final by Westminster. The final was eventually won by The London.

Since sport last appeared in the *Gazette* four weeks ago, three important Rugby games have been played, and the fixture against Old Alleynians was cancelled because of the snow. In the first, Guy's beat Nuneaton 14—13, this victory being achieved late in the second half through a drop goal by Edgar. Nuneaton have had a successful season, and although Guy's were not up to standard, this was not a bad performance. Guy's played away against Gloucester, whose side included the international Ford. Although we lost 16—5, this score does not reflect the run of the game, and Guy's more than held their own.

In the final game, Guy's lost 16—13 to the R.A.F., who were at full strength. This fixture was played before the war, but had been dropped since, and this game was only arranged a month ago. Guy's had a chance to draw the game when they were awarded a penalty very near the end of the game. As so very often happens in similar situations, the kick missed, and Guy's were fairly beaten. It is very much hoped that this will become an annual fixture.

RUGBY FOOTBALL

GUY'S v. NUNEATON

At H.O.P. 13th March, 1965

Result: won 14—13

The Hospital beat Nuneaton by a goal, a penalty goal, a drop-goal, and a try to two goals and a try—the lead changing hands on four occasions. The bright sunshine and a dry pitch promised open rugby, but, in fact, the Hospital's two weeks' lay-off was too apparent, and the game exhibited much indifference by panting exponents. In the Guy's fifteen Morris came in for Myall, who was allowed leave for a matrimonial fixture.

For the opening minutes the Hospital were in charge, and there were hopes of a high score. Too much possession was wasted by poor handling and unnecessary and mis-directed kicking, however, and these mistakes allowed the visitors up to the Hospital's line. A wheel and a half-break by the Nuneaton scrum-half gave their fly-half room to move, and selling two dummies, the latter went over beneath the posts. The try was converted. The Hospital responded to this reversal, and although several chances were missed through lack of support, especially some fine breaks by Edgar, eventually a bout of interpassing between backs and forwards stretched the Nuneaton defence, and Allan went over wide out. The kick failed. Guy's remained on the attack, and from a scrum on the left touchline, Rowlands broke through and passed inside to Baker. With the defence hesitant, a long overhead pass reached Edgar, who passed on to Kerner, who dived over in the corner. Morris converted from the touchline.

In the second half, Guy's continued to gain a fair share of possession, but used the ball unintelligently. Nuneaton were penalised, and Morris increased the lead by a kick near the posts. There, it seemed, Guy's efforts finished, for with all facility, Nuneaton were allowed to make two direct runs to the line almost without challenge. Scoring a try and a goal, the visitors took the lead, 13—11. This scrappy game appeared lost, but in the closing minutes, from a mid-field scrum, thirty yards from the Nuneaton line, the ball went left to Edgar, who continued left, stopped, stepped back inside, and dropped a goal

Guy's made hard work of what should have been a convincing victory against modest opponents A lucky win, but perhaps consolation for narrow defeats sustained on more lively occasions.

Team: A. M. Morris; R. Kerner, J. A. Edgar, A. J. Allan; J. Ross, B. Rowlands; D. R. Bevan, J. E. Davies, P. Ashcroft, A. Fisher, M. Cockburn, A. Kingdon, H. Sharp, C. Neville, I. A. Baker (Capt.).

GUY'S v. GLOUCESTER

At Kingsholm. 20th March, 1965

Result: lost 5—16

Guy's arrived at a wet and slippery Kingsholm to meet a strong Gloucester fifteen, undefeated since January, and also their President—Ex-Guy's man, Dr. A. Alcock, now in his eighty-fourth year. For the Hospital, Rowlands and Ashcroft were unavailable, and Baker was injured. Their places were taken by Edgar, moving from centre to fly-half, C. Lewis, and P. Williams respectively. C. J. Wright, having been out since before Christmas with a shoulder injury, came into the centre, and in the pack Cockburn moved to No. 8, and P. K. Peace reappeared in the second-row.

Gloucester kicked off, and for the first quarter of an hour pinned Guy's in their "25". Attacks went left and right, but versatile defence, aided by several opposition mistakes, kept the Hospital's line uncrossed. Embarrassed by unprofitable possession, a Gloucester centre eventually dropped a goal. The Hospital did not seem less disheartened by this setback, and play returned to the half-way area. The home pack well out-weighed Guy's forwards, and Booth, their scrum-half, was putting their stand-off away with a long, swift service. Gloucester used their possession to kick into Guy's "25". From one such advance, Ford gathered the ball and scrambled towards the line. Seeming to have this wiry ex-International well held, Guy's looked up in dismay at the referee's distant signal for a try. With more resolve, Guy's began to run with what ball they gained. On two occasions well directed grubber-kicks by Edgar and Wright almost led to tries. But, the score remained unchanged, and just before half-time Gloucester lost their hooker.

In the second half, the same pattern of play continued. Guy's kept Gloucester's moves in check with some strong tackling, and made use of possessions so gained. From one such situation, the ball went to Allan in the centre. Accelerating into his stride, he sold a dummy on the Gloucester "25" and then swerved infield, wrong-footed the opposition, and with great speed scored under the posts. Morris converted. Goaded on by this try, Guy's kept up the pressure, and were unlucky not to score again when Kerner seemed well away, only for the preceding pass to be adjudged forward. Towards the end, the weight of the Gloucester pack and their greater share of the ball began to tell. At the expense of some poor falling, the home side were allowed to dribble the ball under the posts for a converted try, and just before the whistle, a fast-moving Gloucester centre cut through the stretched Guy's defence to add another five points.

Team: A. M. Morris; R. Kerner, C. J. Wright; A. J. Allan, J. Ross; J. A. Edgar (Capt.), B. R. Bevan; T. E. Davies, C. J. Lewis, A. Fisher, P. K. Peace, A. Kingdon, H. Sharp, M. Cockburn, P. Williams.

FENCING

GUY'S v. BLACKFRIARS FENCING CLUB

January 28th, 1965. Men's Foil.

Result: won 8—1

A much closer match than the scores indicates. Throughout, the fencing was well control'ed and enjoyable to watch.
Team: R. Jones, 3 wins; C. Durant, 3 wins; L. Cree, 2 wins.

A.F.A. League, London Section, Division A.

Men's Foil

GUY'S v. NEMO FENCING CLUB

Notting Hill Gate, on Friday, 5th February, 1965

Result: won 5—4

A very good performance by some of the more recently acquired members of the Club. L. Cree, especially, fenced calmly and with considerable guile in winning all three of his bouts.
Team: R. Jones, 2 wins; L. Cree, 3 wins; B. Hartley.

A.F.A. League, London Section, Division A.

Men's Foil

GUY'S v. SALLE FROESHLEN

Tufnell Park, on Monday February 15th, 1965.

Result: won 5—4

Salle Froeschlen fielded a much less formidable team than expected, although there were some rather anxious moments: the Guy's team were very pleased indeed to win this match.

Guy's looked set for a win when 4—2 up. Then R. Knight and C. Durant lost the next two bouts by close margins, and the score became 4—4.

E. H. Harley, who had lost his previous two bouts, fenced brilliantly, clinching the match 5—4 for Guy's, by beating his opponent 5—0. Team: R. Knight, 2 wins; C. Durant (Capt.), 2 wins; E. H. Harley, 1 win.

1964-65 United Hospitals Foil Cup

GUY'S v. LONDON HOSPITAL

At London. 6th March, 1965

Result: won 12—4

Guy's have now met the London in the final for the past three years. In 1962 Guy's narrowly won the Cup by one hit, and in 1963 the London won 9—7. We anticipated another hard match this year.

The match began by R. Knight, of Guy's, being convincingly beaten by G. Leckie, of the London, who is an extremely experienced fencer. It was rather disappointing from Guy's point of view to see him in such fine form. Throughout the match he was not given a really hard contest. However, the remaining opposition proved to be less difficult, Martin scoring the only other win for the London. R. Knight fenced well, suffering only one defeat to Leckie.

L. Cree was extremely impressive fencing in his first cup match, receiving no defeats at all in the bouts fenced. J. Cressall was, perhaps, a little off form, gaining only one victory. With the score at 9—4, the London conceded the remaining three bouts to make the final score 12—4.

C. DURANT

CROSS COUNTRY CLUB

Wednesday, 3rd February, 1965.

In this return match against Latymer, Guy's avenged their narrow defeat earlier in the season and won comfortably, taking the first four places. D. Choat had a fine run to win his first race for Guy's. The course was a simplified version of the U.H. course at High Barnet.

Positions. Time
1st—D. Choat, 31.53.
2nd—E. Bowen-Jones, 32.00.
3rd—R. Wilson, 32.16.
4th—A. Lakin, 33.00.
Result: Guy's, 33 pts.; Latymer, 46 pts.

Inter Hospitals' Cross-Country Championships for the Kent Hughes Cup

This is the annual inter-Hospitals- Cup, last won by Guy's in 1959. Bart's were favourites to retain the trophy, with possible challenges from the London Hospital and Guy's. This year a strong team of qualified men was entered and were unofficially placed third.

Guy's had only an outside chance this year, but started well with five in the first twelve places. The going was easier than usual, but E. Bowen-Jones was unfortunate to lose both shoes in one of the boggy patches after only half-a-mile and was unable to regain his position.

P Witting had his best race for a long time, and with his usual fast finish, beat the first London man to take third place in a very fast time. D. Choat again ran confidently and took tenth place, a very promising run in his first season. A. Lakin started slowly as usual but worked his way up to be the third Guy's man home, with R. Wilson close behind. J. Wheeler was the last scoring member of the team, running very well as he had done no training, due to pressure of exams.

WATER POLO

With the success of the United Hospitals' League behind us, hopes are high for the University League, played at U.L.U. In this large pool the swimming speed of the team should be an important factor. Unfortunately, ball-handling and shooting are not yet up to standard, and matches have been lost that could, perhaps, have been won.

The first match, against University College, was lost mainly by lack of fitness, as we were 4—3 up at the beginning of the last quarter.

Queen Mary College did not put up much opposition, but Imperial College gave us a shock. The two hard fought games against I.C. served to pull the team together, and the second game, although lost, showed a great improvement. This improvement continued against St. Mary's, and even with a slow start the team was in complete control of the game with superior speed and tactics.

Team: B. Valentine, D. Barnes, R. Jones, D. Bartlett, K. McGlynn, J. Seigle, J. Holland, A. Forbes.

LADIES' SQUASH

26th November, 1964. Away
Guy's v. St. Thomas's Hospital
Result: lost 1—4

3rd December, 1964. Home
Guy's v. University College
Result: won 3—1

25th January, 1965. Home
Guy's v. St. Bartholomew's Hospital
Result: won 3—0

1st February, 1965. Away
Guy's v. University College Hospital
C. Stannard lost 0—3.
B. Gillian lost 0—3.
D. Winder lost 0—3.
P. Rench lost 0—3.
Result: lost 0—4

11th February, 1965. Away
Guy's v. I.B.I.S.
C. Stannard lost 0—3.
C. Wotherspoon lost 1—3.
P. Hubbard won 3—2.
Result: lost 1—2

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL DENTAL SCHOOL

Applications are invited for the following appointments to commence duties on 1st October, 1965.

Lecturer (full-time) in the Department of Conservative Dental Surgery; Lecturer or Senior Lecturer (full-time) in the Department of Dental Prosthetics.

Salary Scales:

Senior Lecturer: £2,315 x £110 to £2,755 (bar); £2,865 x £110 to £3,085.

Lecturer: £1,580 x £110 to £1,690 x £115 to £2,150 x £110 to £2,480 x £55 to £2,535.

Both with superannuation.

Forms of application are obtainable from, and should be lodged with, the Dean, Guy's Hospital Dental School, London, S.E.1, not later than **Wednesday, 28th April, 1965.**

EVELINA CHILDREN'S HOSPITAL OF GUY'S HOSPITAL, SOUTHWARK BRIDGE ROAD, LONDON, S.E.1.

Applications are invited for the post of **Part-Time, Non-Resident, Casualty Officer** (Senior House Officer Grade) for six months from 1st August, 1965. Six morning sessions weekly. Salary 7/11th of full-time rate.

Applications, and copies of three recent testimonials should reach the Hospital Secretary by first post on **Monday, 10th May, 1965.**

Applications are invited for the post of **Resident Paediatric House Officer** (with casualty duties) for six months from 1st June, 1965. The appointment is recognised for the D.C.H. and consists of four months medicine and two months surgery. Candidates must be registered practitioners and should apply giving age, nationality, qualifications (with dates), and copies of three recent testimonials to the Hospital Secretary by first post on **Monday, 10th May, 1965.**

GUY'S HOSPITAL

HOUSE APPOINTMENTS

June 1st, 1965

Applications are invited for the following House Appointments at Guy's Hospital, due to begin on June 1st, 1965; applications giving choice of post and choice of hospital, in order of preference, should be lodged with Mr. J. B. Blaikley, Superintendent, not later than **April 30th, 1965.**

Assistant House Surgeons
Pre-registration 4

The appointment will be for six months, the first three to be spent as A.H.S. During the second three months of the appointment candidates will move either to the post of Casualty Officer (Surgical) or will remain as A.H.S. These vacancies will normally be open only to pre-registration candidates applying for their first appointment and not to candidates seeking their second six months appointment.

Assistant House Surgeon to the Surgical Unit
Pre-registration 1

Assistant House Physicians
Pre-registration 5

The appointment will be for six months, the first three to be spent as A.H.P. During the second three months of the appointment candidates will move either to the post of Casualty Officer (Medical) or will remain as A.H.P. These vacancies will normally be open only to pre-registration candidates applying for their first appointment and not to candidates seeking their second six months appointment.

Casualty Officers
Pre-registration 6

House Surgeons
Pre-registration 2
Pre- or Post-registration 1

House Physicians
Pre-registration 2
Pre- or Post-registration 1

Resident Obstetrician
Post-registration 1

Throat and Ear House Surgeon
Pre- or Post-registration 1

Orthopaedic House Surgeons
Pre-registration 2

Dermatological House Physician
Post-registration 1
(To commence 1.8.65)

Genito-Urinary House Surgeon
Pre-registration 1
(2nd six months, or post-registration)

House Surgeon to the Thoracic Unit
Pre- or Post-registration 1

Children's House Physician
Pre-registration (2nd six months only) or Post-registration 1

House Physician in Clinical Pathology
S.H.O. 1

R.M.O. in Nuffield House
S.H.O. 1
(To commence 1.7.65)

Resident Anaesthetists
S.H.O. 1
Post-registration 1

The Medical Committee will also consider application for posts at outer hospitals as follows:—

BECKENHAM HOSPITAL

House Physician
Pre-registration 1
House Surgeon
Pre-registration 1

JOYCE GREEN HOSPITAL

House Physician in General Medicine with Dermatology
Pre-registration 1

LEWISHAM HOSPITAL

House Physician to Dr. Roberts
Pre-registration 1
(To commence 15.6.65, locum from 1.6.65)
House Surgeon to Mr. Glyn-Evans
Pre-registration 1
(To commence 15.6.65, locum from 1.6.65)

NEW CROSS HOSPITAL

Senior House Officer in Medicine and Geriatrics
S.H.O. 1
House Physicians
Pre-registration 2
House Surgeon in Orthopaedics and Rehabilitation
Pre-registration 1

ORPINGTON HOSPITAL

House Surgeon with Ophthalmology
Pre-registration 1
(To commence 17.7.65)
House Surgeon with E.N.T.
Pre-registration 1
(To commence 1.7.65)
House Surgeon with Orthopaedics
Pre-registration 1

PEMBURY HOSPITAL

House Surgeons
Pre-registration 2
House Physician
Pre-registration 1

ST. JOHN'S HOSPITAL, LEWISHAM

House Surgeon (General Duties with Gynaecology)
Pre-registration 1

ST. OLAVE'S HOSPITAL

House Physicians
Pre-registration 2
S.H.O. in General Surgery
S.H.O. 1

NOTICE FOR PRE-REGISTRATION CANDIDATES

Pre-registration candidates are reminded that the number of posts at Guy's is small compared with the number of students who are likely to qualify. Students applying at Guy's, therefore, are advised to consider applying for pre-registration posts elsewhere at the same time, in order to avoid delay in obtaining a post. A number of recognised posts is available in the South-East Region. Details of posts in this region and elsewhere in the country are available in the Medical School Office.

Pre-registration candidates who have completed six months in Medical or Surgical posts are reminded that they must now apply for Surgical and Medical posts respectively. A candidate who has completed his first six months in a specialty (Surgical or Medical) may not do another six months in a specialty, but must seek a post in general medicine or general surgery as the case may be, according to G.M.C. regulations.

GUY'S HOSPITAL

Applications are invited for the following appointments to commence on 1st October, 1965:

Department of Conservative Dental Surgery
Registrars to attend full or part-time.

Department of Dental Prosthetics
Registrars to attend on six, five, four, or three sessions per week.

Dental Department for Children
Senior Registrar to attend full-time.
Registrar to attend on six sessions per week.
Orthodontic Assistant to attend on six sessions per week.

Clinical Dental Surgery
Senior Registrars/Registrars to attend full-time.

Department of Preventive Dentistry
Registrars to attend on six, five, or three sessions per week.

Casualty Department
Registrars to attend on six or five sessions per week.

Minor Oral Surgery Department
Registrars to attend on six or three sessions per week

Dental Radiology Department
Registrars to attend on six, five, or three sessions per week.

Dental Officer to treat In-Patients
One Dental Officer to attend on six sessions per week.

Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, London, S.E.1, not later than **Wednesday, 28th April, 1965.**

PASS LISTS

ROYAL COLLEGE OF SURGEONS OF ENGLAND

Primary F.R.C.S.

C. B. T. Adams	J. G. Fraser
M. V. Bright	M. A. Shields
T. A. H. English	M. Singh

F.F.A.
T. M. Bull

Primary F.D.S.

D. A. Ager	H. W. Preiskel
R. P. Juniper	J. H. Topham
P. J. Leopard	D. L Wedgwood
	J. L. Williams

UNIVERSITY OF LONDON
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M. R. Alderson

UNIVERSITY OF CAMBRIDGE
M.Chir.
R. J. Heald

UNIVERSITY OF NEWCASTLE
M.D.S.
L. W. Kay

SOCIETY OF APOTHECARIES OF LONDON
Final Examination
Pathology and Bacteriology
N. W. D. Walshaw

Medicine
N. W. D. Walshaw

BIRTHS

GOWDY.—On 17th November, 1964, at Heswall, to Angela (née Godson, S.R.N., R.S.C.N.) and Donald Gowdy (Lt. Cdr., R.N.) a daughter, Adrienne, a sister for Joanna.

LLOYD-EDWARDS.—On February 21st, at Southampton, to Jennie (née Taylor) and Surg. Lt., (D) Adrian Lloyd-Edwards, R.N., a daughter, Ceri Anne, a sister for Sien.

MARRIAGE

KNELL.—On 20th March, 1965, at Gray's Congregational Church, Essex, Alan J. Knell, B.A., M.B., B.Chir., to Jean E. R. Brown, B.A., M.B., B.Chir.

GUY'S HOSPITAL GAZETTE

FORTNIGHTLY ONE SHILLING VOLUME 79 NUMBER 2002

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EDITORS B. H. HICKS AND P. BOWDEN

SPORTS CORRESPONDENT A. PROCTER

GUY'S HOSPITAL, LONDON

PASSIM

Planning and Families

An excellent review of the subject in the April *Practitioner*, and news that the Dunlop Committee is to investigate the relationship between thrombosis and The Pill, prompt us to examine the place of family planning in the health service. That family planning has place, and an important one, would be questioned by few doctors, who already dispense a considerable quantity of advice on the subject. The formal relationship between family planning and the health service seems less firmly established, however. Much of the help in this field is given in private clinics, outside the umbrella of the National Health Service, and it is to the credit of these clinics and family doctors that the co-operation is so successful. When the problem of increasing population in this country becomes more acute, we may expect to see these clinics incorporated more fully into the health service, in order that their services may be extended to the families in most urgent need of them. Failure to do so may be an economic disservice to the country, let alone the families.

This is not to suggest that such facilities should be provided without charge, although the advice might be, as is any other medical advice affecting the patient's welfare. The cost of contraception could be borne most fairly by those making use of the facility. As has been said here before, the prescription charge itself—perhaps excluding the young and the elderly—was hardly an injustice, and not without its blessings. But our subscribers in practice need no reminding of that.

Discussion of contraception would not be complete without mention of the situation of the unmarried woman, who will find very few clinics to help her. This is obviously a question in which moral aspects play a major role, often a passionately committed one, and such aspects must be given due regard. And this argument is *not* directed at the morality or otherwise of pre-marital intercourse, a matter on which quite enough pontificating already occurs; our argument is based on the liberal nature of our society. In this society, a small minority openly profess their belief in the "new" morality of personal relationships; a much larger group act by it without openly professing the fact (which is not a new situation, of course).

Given this state of affairs, is it right and proper for medical men—or their political peers—to refuse a medical service on grounds of conventional morality? In any other field of medicine such narrow ethics would not be tolerated.

For the minority to whom all aspects of artificial birth control are morally questionable, the situation is in the balance—with the pivot of the balance set in a certain Commission in Rome. Judging

by the tone of the essays in a recent book* by many leading Catholic thinkers, there is hope in that direction too. However, in this matter also it is the right of the patient to choose and morally to judge, not ours. It may be our duty to defend his right.

Physician and Surgeon

Despite their more august ancestry, the Physicians are still looked on by the Surgeons as men who have yet to escape from the "sterility of the humoral philosophies and the frustrations of therapeutic nihilism". They are rather old-fashioned and inactive men of over-considered action and sometimes downright obstruction, they love to sit on cases. Conversely, the Surgeon is considered a rather racey being whose bedside manner makes up, in some measure, for his lack of real academic ability. Surgeons are the therapeutic extremists of medicine.

As specialisation becomes more inevitable, it is important for the two great divisions of physic, medicine and surgery, to make a real effort to liaise, or else their branches will never have any ground on which mutual discussion is possible, only argument. With the building of separate medical or surgical blocks it will be even more easy to divide patients into artificial categories in which one aspect of treatment is altogether neglected. The General Practitioner's decision to send a patient to either physician or surgeon will become of greater importance in those fringe diseases whose treatment can be very different as either a medical or surgical case.

Mr. G. F. Gibberd will deliver the William Meredith Fletcher Shaw lecture, on 24th September, at the Royal College of Obstetricians and Gynaecologists. This lecture is given annually by a senior Fellow of the College, at the invitation of the Council.

Professor R. H. S. Thompson has been invited to give the Jephcott Lecture of the Royal Society of Medicine. The date has not yet been announced.

A Guy's man outside the hospital, Dr. John Fry, has been awarded the James Mackenzie Prize of the College of General Practitioners for research carried out in general practice. This is only the second time the Prize has been awarded, and we offer him our cordial congratulations.

A memorial tablet to the late Lord Cunliffe is to be dedicated in the Guy's Chapel on Monday, 3rd May. A short service of dedication will take place at 12.30 p.m.

**Contraception and Holiness.* Collins, Fontana London, 1965.

We have received unconfirmed reports that a Guy's man was seen with one trouser-leg firmly tied to the railings around Our Founder's statue. Will anyone who saw the accident or can give information, please placate Thomas Guy.

The pastoral panorama of Bermondsey received something of a jolt when another semi-permanent building began laying down roots between New Guy's House and The Miller. Despite one expressed hope, it is not there to accommodate certain "pots", but children. In fact, external colourings aside, the building will provide a much-needed and suitably bright extension for the Child Psychiatric Unit. Even the external appearance is to be improved in the near future, we are reliably informed.

A generous gift of one private donor, and two commercial donors, the unit will house research, teaching and out-patient facilities which include a library and closed-circuit television. The latter should prove of enormous value in teaching, and may also be used in the production of short teaching films. To the donors our sincere thanks, to the new unit our best wishes; and for once we know we speak for the whole hospital.

And to crown it all, seen on the East Wing self-service coffee machine . . .

> *If we sell* 450 *cups per week for a month at* 6*d. for tea and* 6*d. for coffee, then we can drop the price to* 4*d. for tea and* 4*d. for coffee in which case we have to sell* 650 *cups.*

And if we only sell 225 cups they will cost 1s. a cup, and if we were down to 2 cups then it would be £5 12s. 6d. a cup! On the other hand, if we drink 2,200 cups then the price will come down to 1½d. a cup, and at 13,500 cups it will be 0.2d. a cup, which for a machine means putting in a farthing change with the cup, and as a farthing is not legal tender anyway, coffee might as well be free!

GUY'S DIARY

APRIL.

EXHIBITION		*Haematemesis.*
22nd Th.	1.00	Mr. LAWRIE. Clinical Lecture. *The Acute Abdomen.*
26th M.	1.00	Mr. STAMM. Clinical Lecture. *Internal Fixation of Fractures.*
27th T.	1.00	Mr. SCHURR. Clinical Lecture. *The Surgery of Cerebro-Vascular Accidents.*
28th W.	1.00	Mr. WASS. Clinical Lecture. *Carcinoma of the Stomach.*

The Clinico-Pathological Meeting of 24th April has been cancelled.

Aphthous Ulceration of the Mouth and Autoimmunity

THOMAS LEHNER

Apart from dental caries and paradontal disease, recurrent aphthous ulceration is the most common disease of the mouth. The incidence has been reported as 20 per cent in a hospital population (Sircus et al. 1957), and 55 per cent in a student population (Ship et al. 1960). The disease is typical of those of "unknown aetiology" by the multiplicity of micro-organisms, vitamins, hormones, traumatic, psychosomatic and other factors which have been implicated as causative agents. The latest casualty was the Herpes simplex virus, which was shown not to be the cause of aphthous ulcers (Blank et al. 1950).

A new approach to a number of diseases followed Burnet's (1949) introduction of the concept of autoimmunity, and its experimental proof by Medawar et al. (1953). The new techniques developed for the investigation of autoimmune disorders were applied to aphthous ulceration, for it fulfils several of Burnet's criteria for an immunological disorder. Thus, females are more often affected than males, corticosteroids are often beneficial, it is said to be more common in ulcerative colitis, and the early lesion is characterised by an accumulation of lymphocytes and mast cells, and some neutrophils, histiocytes, plasma cells and eosinophils.

The aim of this investigation was to apply the sensitised tanned red cell haemagglutination technique of Boyden (1951), the complement fixation test, and the Ouchterlony precipitation test to sera from patients with aphthous ulcers and with other diseases, as well as from control subjects. A saline extract of foetal oral mucosa was used as the sensitising agent. Blood was collected from 181 subjects, and the serum was stored at $-20°C$. The sera were classified as shown in the table.

Haemagglutination Test

The principle of the haemagglutination technique is that red cells may act as sensitive indicators of antigen-antibody reactions. If red cells are tanned antigen can be coated on their surface. If these antigen sensitised cells come in contact with the specific antibodies an immunological reaction takes place resulting in agglutination of the red cells.

In this series (Lehner 1964) a suspension of 2 per cent sheep erythrocytes was treated with 1/20,000 tannic acid, and then sensitised with a saline extract of oral mucosa. The latter was prepared by excising the buccal mucosa from a stillborn 38-week-old male infant. The tissue was cut finely and homogenised with four times the corresponding volume of saline.

The test serum was serially diluted with buffered saline from 1/2 to 1/1024. One drop of the sensitised cells was added to ten drops of each of the prepared sera; these were kept overnight at 4°C., and

read next morning. Four sets of controls were set up with each series; a known positive serum, a negative serum from a control subject, the saline diluent, and every serum was used with tanned unsensitised cells. The test was repeated at least twice for each serum. Immune absorption tests were carried out with the mucosal extract on strongly positive sera, which were then used in the haemagglutination test. The test was also carried out using liver, colon and skin homogenates as the sensitising agents.

Results

The results are presented in the Table. The agglutination titre in healthy controls and patients with systemic disease did not exceed 1/32. But 7 per cent (2/30) of the non-ulcerating mouth lesions, and 10 per cent (4/40) of the ulcerating lesions gave titres of over 1/32. This proportion rose to 75 per cent (45/60) in patients with aphthous ulcers. Thus, serum from patients with aphthous ulcers caused a specific agglutination of cells that had been coated with an extract of oral mucosa in higher titre and greater proportion than did those of controls and of other diseases. Moreover, no appreciable difference could be detected between the other ulcerating and non-ulcerating lesions. The evidence, therefore, suggests that this is more than an immunological reaction to non-specfic mucosal damage. The negative controls set up with each series did not cause haemagglutination. Absorption of strongly positive sera with the homologous antigen before the test abolished haemagglutination or caused considerable decrease in the titre. Furthermore, significant antibody levels were not shown with liver, colon and skin sensitised red cells.

Precipitation Test

Ouchterlony's agar precipitation technique was used. The working principle here is that if antigen and its specific antibody are placed in separate wells in agar plates, and the reactants are allowed to diffuse, they will form a precipitation line at the point of contact. The saline extract of oral mucosa was set up against the patient's serum, in a number of dilutions. Since precipitation lines were not

	Haemagglutination Test			C.F.T.	
	No. of Subjects	% giving titres of: <1/48	>1/32	No. of Subjects	% giving +C.F.T.
Healthy Controls	20	100	0	16	6
Controls with Systemic disease	15	100	0	11	0
Non-ulcerating Mouth lesions	30	93	7	30	17
Ulcerating Mouth lesions	40	90	10	50	14
Aphthous Ulceration	60	25	75	74	65

Results of Haemagglutination and Complement Fixation Tests

formed it was concluded that precipitating antibodies were absent, or not present in sufficient concentration to be demonstrable.

Complement Fixation Test

The principle used is the same as that in the Wasserman test. A known amount of complement is added to the antigen-antibody reactants. If both the latter are present complement is fixed, and this is demonstrated by the failure of haemolysis in a haemolytic system indicator. In the present series a "4 drop" complement fixation test was used, modified from Donnelley (1951). All sera were decomplemented and diluted 1:4 in barbitone buffer pH 7.2. Fixation was allowed for 45 minutes at 37°C. using two 50 per cent haemolytic doses of complement. Controls were set up with every batch of sera tested, and these included known negative and positive sera, complement, buffer, serum, antigen and cell controls. A positive reading was recorded if less than 50 per cent of the red cells were haemolysed while the corresponding control without antigen showed 100 per cent haemolysis. The results are shown in the Table, and indicate that the test is positive in a larger proportion of patients with aphthous ulcers (65 per cent) than controls and patients with other lesions (combined figure of 12 per cent.)

Discussion

It is generally agreed that in order to establish an autoimmune link in a disease it is desirable, if not essential, to demonstrate humoral antibodies by more than one technique. It is therefore significant that antibodies have been demonstrated in aphthous ulceration by the haemagglutination and complement fixation, though not precipitation technique. Moreover, preliminary immunofluorescent tracing of biopsies of aphthous ulcers suggests the presence of gamma globulin in the cytoplasm of foci of spinosal cells of the epithelium.

The rôle of these antibodies in the pathogenesis of aphthous ulceration cannot as yet be determined. This is, however, the problem facing all autoimmune diseases, namely whether the antigen-antibody reaction is capable of producing the pathological lesion. That this is possible has been shown convincingly only in autoimmune haemolytic anaemia in which adding the serum antibodies to red blood cells causes haemolysis. Furthermore, Pulvertaft et al. (1959) showed that adding thyroid antibodies to thyroid tissue culture cells produces cytotoxic effects in these cells.

If autoantibodies were found to be responsible for aphthous ulceration, it would rationalize the use of corticosteroids, which are so commonly employed in the treatment of these lesions.

The concept of antibody "cross-reactivity" raises another important possibility. It is now fairly well established that normal tissues may share similar antigenic determinants with micro-organisms. Thus, haemolytic streptococcus group A shares an antigen with human heart, so that antibodies elicited by the bacteria cross react with human heart, as occurs in rheumatic carditis (Kaplan 1963). Another example is the cross-reactivity between Esch. coli 014 and colonic

mucosa shown by Perlmann et al. (1964), and they suggest that this antibody is involved in ulcerative colitis.

It is conceivable that the antibodies shown in aphthous ulceration may cross-react with oral mucosa and an infective agent. While this possibility should certainly be explored, it is of interest to note that Barile et al. (1964) have suggested that the "L form" organisms may be the aetiological agents in some types of aphthous ulceration. The "L form" theory requires experimental proof to show that these organisms and their antibodies are predominantly present in patients with aphthous ulcertation but not in normal controls. However, it would be of considerable interest if an antigenic cross reactivity between "L forms" and oral mucosa was established.

While an auto-immunological approach to the problem of aphthous ulcers has yielded some interesting information about humoral antibodies, the part played by these in the pathogenesis of aphthous ulceration must await further elucidation.

ACKNOWLEDGMENTS.

I am greatly indebted to Professor M. A. Rushton for his advice and encouragement, and for allowing me to investigate his patients. I am most grateful to Dr. M. H. Lessof for his generous advice and helpful criticism; and to Miss E. D. Clarry, Mr. C. Theophanides and Mr. T. R. Nichols for their valuable technical assistance. My thanks are also due to Dr. J. R. Trounce and the members of the interdepartmental laboratory committee for permission to use the facilities of the interdepartmental laboratory.

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OBITER SCRIPTA

Seen in the " Cardex ":

MARITAL STATUS: Widow.
NEXT OF KIN: Husband.
TELEPHONE: Nearest police station.

ASTHMA IN CHILDHOOD

BRUCE PEARSON

Asthma is one of the few disorders that is seen as commonly in children as in adults. Approximately 40 per cent. of patients attending an adult asthma clinic have had their first attack in the first ten years of life. Up to the age of ten males are more commonly affected than females, but after this age females preponderate.

Morrison Smith investigated the prevalence of asthma in Birmingham school children and found it present in 2.5% of boys and 1.02% of girls between 5 and 6, and in 2.33% of boys and 1.2% of girls between 10 and 11. Kraepelin found asthma in 0.73% of children attending elementary schools in Sweden, but in a special study of 60,000 children in Stockholm it was present in 1.39%.

DIAGNOSIS

The diagnosis is not difficult in the typical case—a child subject to sudden bouts of wheezing dyspnoea which may be precipitated by contact with known allergens, with upper respiratory tract infection or apparently "spontaneously". He is liable to develop these attacks at night when they may wake him from sleep. In between attacks he is quite well and can carry out all the activities of his age in competition with others. More severe cases are seen, often with a history of flexural eczema during the first few years of life who not only have acute attacks of wheezing, but are dyspnoeic on effort in between attacks so that the amount of exercise they can take is limited. These children can be shown to have persistent airway obstruction between attacks by means of respiratory function tests. In some cases if the asthma commences before the age of three, the thorax shows a pigeon chest deformity with a prominent sternum and flattened lateral aspects of the chest wall, so that it is almost triangular in cross section. After three the rib cage is more resistant and deformity is rarely seen. The spine is often characteristically kyphotic, and if this kyphosis is not corrected before adolescence, it may become permanent.

More difficulty in diagnosis is experienced in the child who presents with an "acute wheezy chest". As Fry has pointed out, this is very common in childhood, affecting as many as one in five children during the first decade. They usually start as an upper respiratory tract infection, and rapidly become wheezy often with cough and scattered sibilant rhonchi. They are usually pyrexial. The differentiation between acute bronchitis, and what is sometimes termed bronchitic asthma, is often impossible at this stage. Many children have one or

two attacks and then lose their symptoms entirely, a fair proportion develop chronic or recurrent bronchitis, and about 10% eventually develop typical attacks of asthma.

Similar attacks after upper respiratory infections occur in a high proportion of children with "typical asthma", especially during the winter months.

Flexural eczema commonly precedes or is associated with childhood asthma, and these children in most cases also have nasal symptoms as well. In a series from my own clinic recently analysed, 41% of asthmatics under 10 years suffered or had suffered from flexural eczema, and 33% of those between 10 and 20 years. When wheezing occurs in a child who has had flexural eczema in infancy, asthma is almost certainly developing. This group of cases is particularly liable to have allergic factors responsible for precipitating attacks, and a high proportion have a family history of allergic disease. The majority of cases of food allergy are in this group.

PROGNOSIS

The prognosis of asthma in childhood is undoubtedly far better than in adults. Rackemann and Edwards followed up 688 children after a period of 20 years: of these, 449 attended before the age of 13. Of the 449 younger age group, 30.7% were thought to have been cured, and a further 19.3% had minimal symptoms, but knew that contact with animals or pollens to which they were known to have been sensitive still caused symptoms of asthma. Symptoms of asthma were still commonly present in 28.4%, and this figure included eleven cases who had died, four of them in acute asthmatic attacks. Ryssing followed up 298 asthmatic children in Denmark 18—37 years after their first attendance, and found that 106 had no attacks for more than a year, and of these only 58 had been free for the previous 13 years. Acute attacks still took place in 165, and ten (3.4%) had died from asthma. The association with flexural eczema affects the prognosis adversely: among my own cases only 1 out of 11 children with eczema lost his symptoms compared with 10 out of 25 without eczema when followed for periods of from 3-7 years.

AETIOLOGY

Although these figures provide grounds for limited optimism, they are not so good as to suggest that the parent of the asthmatic child can be reassured with a pat on the back and a supply of ephedrine tablets. Every means of assessing the precipitating factors in each case must be taken: to do this need not alarm the parents or the child, particularly when definite measures for reducing the number and severity of attacks can be recommended. Particular trouble should be taken in those children with a history of flexural eczema, attacks of status asthmaticus or chest deformities and kyphosis. Children who lose much time from school or who are abnormally small for their age also need special attention.

As in adults, emotional, allergic, or infective factors may precipitate attacks, and a careful history is the most important means of investigation. Not only may this elicit facts of importance, but it helps to educate the parents as to the kind of thing which may be important and which they may recognise later.

EMOTIONAL FACTORS

Perhaps the first point to establish is the relationship that exists between mother and asthmatic child. Is there a loving relationship with obvious understanding between the two, or does the child remain aloof and resentful while the mother recounts the details to the doctor? Is mother over anxious, or is she more annoyed than worried about nocturnal attacks? Is the child so hedged in with restrictions that he has no chance of developing independence, often clinging to his mother and refusing to be separated from her? Does he get on with his siblings and was there any relationship between the onset of his attacks and the addition of a new member to the family? Sometimes parents who have wished for a boy, may be unable to suppress their resentment when a girl arrives; others lose interest in the first child when a second is on the way. Parental quarrelling is a potent cause of insecurity, and fathers who are over-critical and forget to praise where praise is merited cause lack of confidence.

All children require a secure background from which they can make sorties into independence, and lack of security is particularly important as a cause of symptoms in children with asthma. Over protection leads to insecurity, but if the child is resented or unwanted, he senses this and is even more insecure. The mother of the asthmatic child should demonstrate her love for him, but should encourage him to lead as normal a life as possible, giving him small responsibilities and allowing him to play with other children, encouraging him to leave the family circle, but always providing a warm welcome when he comes back.

The family doctor will probably know what the home background is, but in hospital practice it may take several visits to the clinic, and perhaps a home visit by the social worker, to bring out the essential facts. The parents and especially the mother may have problems of their own, and helping them to deal with these may relieve their anxiety and bring about an improved relationship. If such problems can be freely discussed with intelligent parents, preferably in the absence of the child, they may be enabled to adjust conditions at home with considerable benefit to the child's asthma.

At this point one must refer to the insecurity that attacks of asthma themselves may cause. This depends very largely upon the parents' attitude to attacks. Sympathy in moderation and reassuring calmness is required from the parent, and this can obviously be helped by an effective symptomatic remedy. The scared parent frightens the child and makes his asthma worse.

Psychological factors are probably rarely the primary cause of asthma, but their presence will materially alter the prognosis in the child with asthma. A secure and happy child will cope with his asthma much better than an insecure unhappy one.

ALLERGY

Allergy plays a prominent part in childhood asthma, and parents should always be asked if they have noticed that contact with household pets causes wheezing or sneezing. This may be denied at the time, but subsequent observations may convince them that this is so. A small boy who was known to be strongly allergic to eggs continued to have attacks after all egg products had been removed from his diet. These were so severe that he had to be admitted to hospital on a number of occasions in status asthmaticus. He was eventually sent to a residential school where he improved considerably, but his return home for the holidays was always shortly followed by severe attacks. It took his mother some time to appreciate that the worst attacks occurred after close contact with the family cat. On one occasion he was admitted to hospital unconscious after playing with it on the bed for two hours. He also had bad attacks when visiting an aunt who possessed a cat with which he played. In this case the attacks were so severe that the pet was given away and the attacks ceased. In milder cases this may not be necessary, and all that is required is to avoid close contact and especially to keep pets out of the bedroom. It is always worth asking about the effect of visits to the Zoo or to the circus, which will often cause attacks in those sensitive to animal hairs.

Pollen sensitivity is more common in older children. Attacks may be limited to June and July when the diagnosis is easy, but in many cases pollen is only one of a number of factors and may be overlooked unless questions are asked as to the effect of caravan holidays, mowing the lawn, or visits to parks or fields during the early summer. If attacks are severe in the latter part of the summer, sensitivity to mould spores may be responsible.

Household allergens are often important, and all asthmatic children should have clean and relatively bare bedrooms, with rubber foam or terylene filled pillows. The mother may have noticed that dusting, spring cleaning or bed making causes sneezing or wheezing.

Food allergy, though not commonly a cause of asthma, is most often encountered in the first two years of life especially in those with infantile eczema. It may cause swelling of the lips or vomiting rather than asthma, but in some cases sensitivity is so great that even traces of the offending food will lead to severe attacks of asthma. If food sensitivity is suspected, a diet must be devised from which the potentially offending foods are eliminated for a trial period. If doubt still remains, the child may be challenged with increasing amounts of the suspected food. Eggs, milk, nuts and fish are the commonest offenders. Sensitivity to eggs and fish may be so great that even skin tests by the prick method may cause severe anaphylactic shock and should therefore never be carried out when the history is definite. Fortunately food allergy is a rare cause of asthma after the age of ten.

Skin tests by the prick method often provide hints as to possible sensitivity to air borne allergens, but are seldom of value in food allergy. If properly carried out they should not be painful. Desensitisation may be helpful when the history is definite, but it is rarely completely successful when the child is still in close contact with the allergen. Its effect is moreover only temporary.

INFECTION

Infection is the third factor of importance which is known to precipitate attacks of asthma. The mechanism responsible for this is still undecided, but recent work by Hampton, Johnson and Galakotos suggests that genuine allergy to respiratory tract bacteria, not necessarily pathogenic, may be important.

TREATMENT

From what has been said, it is obvious that treatment consists largely in advising parents regarding possible situations in the home environment which may be affecting the child's asthma through emotional channels, in discovering and avoiding allergens which may precipitate attacks and in taking steps to deal with infections of the respiratory tract when they arise, with antibiotics if necessary. The use of bronchodilator drugs is valuable in the milder cases, particularly those with nocturnal attacks. Antihistamine syrups are often valuable in these cases and may safely be given at night for a long period of time to break the asthma habit. Antihistamine preparations are, however, of no value in severe asthma. Ephedrine is well tolerated by children and rarely has the effect of interfering with sleep, a side effect common in adults: in fact it often causes drowsiness and can be given in doses of $\frac{1}{8}$ grain up to 2 years, $\frac{1}{4}$ grain up to 6 years, and $\frac{1}{2}$ grain after this age at bedtime, if necessary incorporated in the antihistamine linctus. Relaxation and breathing exercises may help the older child.

When asthma is severe and recurrent, a dramatic improvement sometimes follows a period in a residential school where the staff are familiar with the care of asthmatic children. Improvement may take place for a number of reasons, of which the most important are probably (1) adequate space and a regular life, (2) confidence and absence of fuss on the part of the administrative staff with an optimistic outlook concerning the future of asthmatic attacks, and (3) removal from home allergens or a strained emotional atmosphere. Some children relapse at once on return home, others maintain their improvement.

If all other measures fail and particularly if development is retarded, and the child is severely handicapped physically, and as regards his education, then long term steroids may be justified. By this is meant the administration of prednisolone, betamethazone or other steroid preparation for a period of 3 months or longer. It should rarely be necessary to give more than 10 mg. of prednisolone daily, and bigger doses will inevitably cause Cushinoid symptoms and may arrest skeletal growth, if maintained for more than a few weeks. Chronically asthmatic children can be kept reasonably well on a maintenance dose of 2-10 mgm daily, which is unlikely to affect growth. Following a period of relative freedom from asthmatic attacks, an attempt may be made to reduce the dose. This can most easily be done by giving prednisolone in 1 mgm tablets rather than 5 mgm, so that very gradual reduction can be carried out. If the child passes through a bad spell, the dose may have to be temporarily increased. The disadvantages are that weaning the patient off the drug may be difficult, that in really severe cases steroid treatment may have

to be continued indefinitely, and that suprarenal suppression or even atrophy may take place. The child is therefore at risk for a period of at least 2 years after the steroid has been stopped, and attacks of asthma during this period should be controlled at once with short courses of steroids. It should not be necessary to treat more than 1 or 2% of children with steroids on a long term basis, and even in these cases the physician is not relieved of his responsibility for constantly seeking out and attempting to deal with underlying precipitating factors.

Children between 3 and 10 years with status asthmaticus or severe attacks not amounting to status usually respond well to aminophylline suppositories 100-180 mgm according to age, and small injections of adrenaline hydrochloride 1 : 1000 (0.2—0.5 ml). If the aminophylline has to be repeated, the child should be observed for evidence of over dosage as shown by restlessness, vomiting and sometimes convulsions: vomiting is however common during severe asthmatic attacks. Some authors (Gairdner 1964) advise a maximum of 15 mgm per kilogram in 24 hours. Because children are apt to be frightened during bad attacks, a sedative such as chloral hydrate 250 mgm may be given and repeated if necessary in 4 hours. It is important to remember, however, that the aim is to soothe and not to cause sleep—since doses large enough to send the child to sleep if severe wheezing is present will almost certainly depress the respiratory centre and may have fatal results.

If these measures fail to produce a response, steroid or corticotrophin should be given. Hydrocortisone 25 mgm may be given intravenously preferably in a drip, since in this way dehydration, which may be an important complication, can also be prevented. Prednisolone in an initial dose of 5-15 mgm and repeated in 5 mgm doses may be given 6-8 hourly up to a total of 20-30 mgm during the first day, and can be reduced gradually over the next week. These preparations often take 24 hours to exert an effect, and in the meantime symptomatic remedies of the type already mentioned may have to be repeated. If vomiting is present or the attack has lasted more than 24 hours, dehydration may easily develop especially in small children, and measures must be taken to combat this and to maintain a normal electrolyte balance. For more exact details concerning dosage a children's pharmacopoeia should be consulted.

The problems associated with asthma in childhood are always interesting, though the individual patient may be a cause of considerable anxiety. The natural tendency to recover, shown by children in so many diseases, offers hope for the future, and guiding the parents and child through the difficult years to eventual recovery with development into normal adolescence can be a rewarding experience.

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NOTICES

Guy's Hospital Ladies' Association

During the past two weeks new stethoscope earphones have been supplied to the whole of New Guy's House by the Trolley Service at the cost of £700. Also supplied to various wards were electric razors, floor heaters, bookcases, hair dryers and shaving mirrors. These articles are greatly appreciated by the patients, particularly the earphones, many of the old ones being past repair. What can be more depressing to a patient than to be in bed with just nothing to listen to? I have experienced this.

K. CROUCHER (*Hon. Organiser*).

Guy's Hospital East Anglican Dinner, 1965

The Guy's Hospital East Anglian Dinner for 1965 will be held on Friday, 21st May, at the Royal Air Force Hospital, Ely, at 7.30 for 8.0 p.m. President: Group Captain G. H. Dhenin, A.F.C., G.M., M.A., M.D., D.P.H., R.A.F, Guest of Honour: Mr. T. L. T. Lewis, F.R.C.S., F.R.C.O.G. If any Guy's man in East Anglia has not received a notice of this dinner, but would like to come, will he please write to Dr. A. Batty Shaw, 41, Newmarket Road, Norwich.

South Wales and Monmouthshire Branch

The 14th Dinner of the above Society was held at the Park Hotel, Cardiff, on Saturday, 13th March, 1965, on the evening of the Wales v. Ireland International Match. It was pleasing to see the largest number ever present—60—which included two guests from Guy's—Mr. J. Mansie and Mr. J. Goodliffe. The President for the year is Mr. Morwent Brown, one of the founder Secretaries. It is hoped this will continue to go from strength to strength, and all Guy's men are welcome to attend next year on the evening of the France v. Wales game in March. The President-Elect is Mr. Hugh Harley.

Missing Volumes

The following volumes are missing from the Pathology Library, and it would be greatly appreciated if they could be returned as soon as possible:—*Annual Review of Microbiology*, vol. **14** (1960), **15** (1961) and **16** (1962).

Student Education Committee

The first open meeting of the Student Education Committee will be held on Thursday, 29th April, at 4.30 p.m., in the North Common Room. It is hoped that as many students as possible will be able to attend.

CASE REPORT

Patient: A. Doll. **Ward: Charlotte.**

Under the care of: Dr. MacKeith.

c/o Strabismus for unknown length of time.

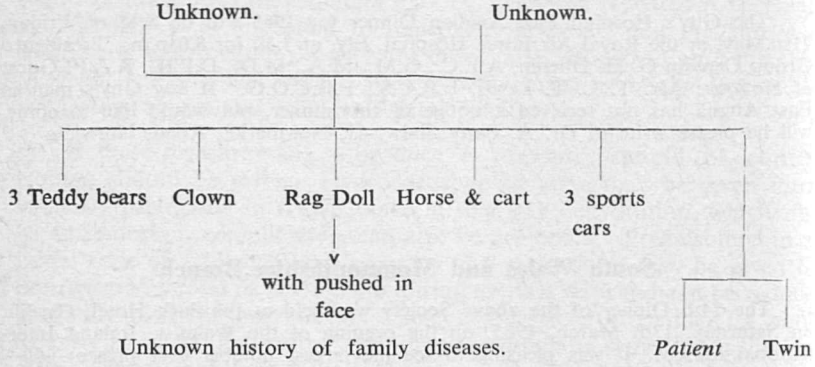
Present Complaint

Strabismus first noticed by Dr. MacKeith on ward round on 20.12.64 as an incidental finding. It is not known why the doll was originally admitted, but it was probably on account of its small size, absence of heart sounds or attempts at respiration despite its pink coloration.

Past Diseases

Unknown.

Family History



Unknown history of family diseases.

Social History

Lives in dry cupboard with 11 shelves. No bathroom or W.C. This is shared with all the above mentioned sites plus 50 jigsaws. Maternal deprivation.

On Examination

R.S. Small doll. Not anaemic. ? Albinism. Does not move at all. Seems unaware of surroundings and does not cry or make any sound. Strabismus of R eye.

C.V.S. Pulse nil. BP unrecordable. SVP not raised. Apex beat impalpable. Heart sounds not heard. No thrills or murmurs. Femorals not felt.

R.S. Trachea central. No movements. No breath sounds or adventitia.

A.S. Mouth—? lockjaw (unable to open). Abdomen—rigid. No organs palpable. Per acetabulum it was found that no abdominal organs were present.

RES. No lymph glands palpable.

CNS Completely unresponsive to surroundings. Unintelligent, unco-operative. ? Dead.

Cranial nerves.

I. Unable to distinguish between soap and orange.

II. Fundi not seen—unable to see retina. Pupils do not react to light or accommodate.

III, IV, VI. Medial strabismus of R eye. No eye movements detectable except on shaking.

V—XI. Response poor to all tests.

Sensory System. No appreciation in any part of body.

Motor System. Spastic tetraplegia. Hypertonicity. Power nil.

Reflexes. Absent on both sides.

Summary

A small doll of indeterminate sex and unknown age, who on examination is completely unresponsive to surroundings, is pulseless and makes no attempt to breathe.

Plan

To be seen by consultant to be making attempts to correct squint.

Progress

Surgery now performed to correct strabismus of R eye. This was successful at first, but subsequently relapsed.

1.1.65 In view of failure of surgery, L eye was patched and glasses made.

12.1.65. *R. C. MacKeith.* As the increased resistance to passive movement of the segments of the limbs above the joints is in *both* directions, and as there is no "give" or "catch" or other evidence of over brisk stretch reflex, I would describe the hypertonus as rigidity rather than spasticity.—*R.C.M.*

Sports Day

SATURDAY, 29TH MAY.

For running, jumping and standing still . . .

SPORTS DAY,

Athletics, sideshows, dance, et al . . .

HONOR OAK PARK.

Residents' May Ball

Tickets are now available for the *Residents' May Ball,* which is to be held at The Pigalle, Piccadilly, on Friday, 21st May, from 8 p.m. to 3 a.m. There has already been a considerable demand for tickets for this function, and therefore guests are advised to reserve their tables at an early date. Applications for tickets should be made to either the President of the Residents or to myself, care of The East Wing, Guy's Hospital.

D. K. C. COOPER
(*Chairman of the Ball Committee*).

OBITER DICTA

DR. MOYNAHAN: . . . *" Of course, I don't pretend to teach you about skin conditions . . .*

DR. HOUSTON (*examining skull X-ray*): *" Opinions on the amount of deviation of the pineal compatible with normality differ. I should say that half a centimetre was the limit. What do you think, Dick?"*

REGISTRAR (*sincerely*): *The figure that I have in mind is five millimetres, sir, which is about half a centimetre, isn't it?"*

CORRESPONDENCE

Mr. E. G. Slesinger

SIR,—Mr. E. G. Slesinger will retire as Chairman of the Board of Governors on Monday, 31st May, 1965, having served as Vice-Chairman from 1948 to 1964. He came to Guy's as a Medical Student in 1905, and has a unique and quite outstanding record of valuable service to the Hospital and School over all these years. We are sure that many of Mr. Slesinger's former colleagues and other members of all sections of the staff who have known and worked with him would like to join us in a presentation which is to be made to him on his retirement.

May we ask that contributions should be sent to the Clerk to the Governors, and if by cheque it should be made payable to Guy's Hospital.

Yours, etc.,

A. E. ORCHARD-LISLE, *Vice-Chairman of the Board.*
ROWAN BOLAND, *Dean of the Medical and Dental Schools.*
R. J. CANN, *Chairman of the Medical Committee.*
A. M. JOHNSON, *Matron.*
J. B. BLAIKLEY, *Superintendent.*
A. H. BURFOOT, *Clerk to the Governors.*

Guy's Hospital, S.E.1.

Thoughts on Education

SIR,—Because we are faced with a shortage of doctors, it has become fashionable to talk of introducing a course of general practice into undergraduate teaching. Already thousands of student-hours are wasted every year by partly-trained students hanging around a general practitioner for a brief week or so to observe him make his "200 symptom-decisions a week", which have to cover every aspect of medicine.

General practice is the most " post-graduate " of all medical subjects: Symptom-decisions can only make sense when one has completed a full course of the principles of medicine. To introduce "General Practice Teaching Units" into undergraduate teaching hospitals may be intellectually titillating for the staff, but is educationally dangerous for students still uncertain of the facts on which the decisions have to be based.

Those who wish to "gain the experience and sympathy for the problems that confront the doctor outside a hospital", can easily do this by acting as locum for a general practitioner for a few weeks. It means giving up one's holiday, but this is a small price to pay for the invaluable, corrective post-graduate education one gets through having to face up to those 200 symptom-decisions; and one certainly gains a great deal of sympathy for the doctor who cannot defer his decisions by "waiting for the results of further investigations." In the long run, it also makes for better teaching by those who are responsible for undergraduate medical education, without the necessity for further demands on the students' time through compulsory attendance at a course in " general practice."

Yours, etc.,

ROBERT MAHLER.

Department of Medicine,
Guy's Hospital, S.E.1.

SIR,—It is no doubt merely a coincidence that Professor Butterfield's interesting article appears in the same issue of the *Gazette* as Dr. Pedoe's account of his brief experience in General Practice, and Dr. Millis's letter on the same

subject; with the contents of which I heartily agree. Yet these three communications are surely germane to one another.

Professor Butterfield clearly aims to produce the super-doctor of the future. Whilst one readily concedes that all knowledge and all experience are useful, how far and how really necessary to the future G.P. are the postulates which Professor Butterfield lays down. Dr. Pedoe enumerates details of the kind of life which I myself experienced in nearly 40 years of single-handed practice, and the sort of life which can at times be very burdensome even to one devoted to his profession. Dr. Millis tells us how readily (because the circumstances of General Practice make it so) newcomers fall into line with the routine of General Practice as carried on by their forebears.

The sad thing is that most of the pontifications about General Practice seems to be done by people who have never done any. Might one therefore suggest, with all deference, that all doctors of whatever kind and degree be compelled to do at least a year in General Practice after qualification. Thus, by seeing how the other half of the medical world lives, they will come down from their ivory towers. Medical journals make dark references to "new diseases" as if they cropped up every week, and more than hint that something must be done to make the G.P. more capable of dealing with them. Mummies thousands of years old reveal the presence of arthritis and varicose veins, and these diseases still haunt our surgeries. It is likely, therefore, that the complaints which Dr. Pedoe notes as occupying so much of the time of the G.P. will continue to do so for long enough yet, phenylketonurea and such rare oddities notwithstanding.

"To-morrow! Why, tomorrow I may be
Myself with yesterday's seven thousand years."

Yours, etc.,

G. L. DAVIES.

Hillside, Midford, Bath.

SIR,—I would like to register the appreciation which a great number of students feel for the work Professor Butterfield has put in with our interests in mind. But at the same time, I must express a little sadness on reading in the Professor's article that "various points have arisen, many from discussions with colleagues, some from research with colleagues", and one is forced to the conclusion that he appears not to have sought any student opinion on the matter. I'm sure this will turn out not to be the case. Perhaps in the new wave of thinking (whatever happened to the last one?) that we are told is taking place at Guy's, we are *all* the Professor's colleagues.

Yours, etc.,

CHRISTOPHER DAVIES.

The College,
Guy's Hospital, S.E.1.

Auxiliaries to Whom?

SIR,—Professor Butterfield's stimulating article postulating new ideas for a medical curriculum made most interesting reading. However, in the section headed "The National Health Service—What are we training doctors for?", the Dental School was apparently grouped together with the Nursing and Physiotherapy schools as a place for training medical ancillary services.

As a result of the Dentists' Act of 1921, the dental profession was empowered to employ ancillaries for specified purposes and under certain conditions. It is interesting to note that some ancillaries have been trained at Guy's Dental School for many years, including dental technicians, radiographers and dental chairside assistants. During 1962 the school commenced a training course for dental hygienists who became eligible to qualify and carry out limited procedures on patients under the Dentists' Act of 1957.

In case there is any confusion, it should be borne in mind that the numbers of dental ancillaries trained per annum is only quite small compared with the number of graduates produced each year, and it should be noted that the Dental School is not a training establishment for medical ancillaries, as dental surgeons

gained autonomy under the Act of 1957 when the General Dental Council was formed. Nevertheless, one of the aims of training the dental graduate is to encourage the management of the dental ancillary services available in the most advantageous manner, and perhaps this point will be emphasised in a future series of articles on dental education.

Yours, etc.,

D. LONDON.

Dental Department,
Guy's Hospital, S.E.1.

. . . and of the Student's voice

SIR,—I have read in the recent issues of the *Gazette* the great concern over the unfortunate lack of contributions from the student element of this hospital. I cannot wholly agree with the argument that many students have been contemplating putting pen to paper, but have been discouraged by fear of retribution from the "gods." I do not think this is true in the majority of cases, and fail to see why the administration should suddenly change its attitude towards the students after many years of apparent non-interference. I think the basic problem has been overlooked. The majority of students appear to be simply apathetic, and assume a nonchalant outlook whenever any extra-curricular demand is made of them. There may be many valid reasons for this. Perhaps if the student could be made more aware that he is not only an important but vital factor in the structure of a modern teaching hospital, he may respond a little more enthusiastically.

Yours, etc.,

ROBERT LANE.

The College,
Guy's Hospital, S.E.1.

Guy's Park

SIR,—Spring is once more with us and we look forward, we hope, to a good summer. A new firm of gardeners are just starting to look after the park, and it would be a pity if their efforts were spoilt through lack of appreciation on the part of the many users of this most attractive open space.

It would assist greatly if everyone would help keep the park tidy and would throw newspapers, half-eaten apples, cigarette cartons and other rubbish in the litter baskets; also, if litter is left lying around, that those who observe it would kindly pick it up and dispose of it. On no evening for the past ten days have I walked through the park without picking up at least one newspaper and a number of other bits of rubbish. Whereas visitors may occasionally leave something on the seats, most is almost always rubbish left by Guy's people.

It would also help if people do not walk across the lawns simply so as to take a short cut to the Nurses' Home or elsewhere, as an ugly path is soon worn. Lastly, a great deal of wear of the grass would be avoided if those seats, which properly stand on areas of stone paving, were allowed to remain there instead of being carted all over the place and left in the middle of the lawns.

Yours, etc.,

J. B. BLAIKLEY.

Superintendent's Office,
Guy's Hospital, S.E.1

Bertie Lees Read

SIR,—I have just received the March copy of *Guy's Hospital Gazette*, which, as usual, I read with much interest.

It was with feelings of great pride that I noticed the two references to my late husband, Bertie Lees Read, and to know his name is still so well remembered and respected in the hospital. My great regret is that he did not live to see the fulfilment of his ambition in connection with the rebuilding of the hospital, in the original planning of which he played an important part. He would have been so proud of what has been done, as indeed are all of us who have the privilege of being connected with the hospital.

May it continue for many years in its great work of caring for the sick.

Yours, etc.,

LYDIA LEES READ.

104, Priory Lane,
Roehampton, S.W.15.

Dental Society Dinner

SIR,—May I through the courtesy of your columns, thank all those who so generously contributed £4 9s. 5d. to our fund. They will, I know, be surprised to learn that, through no fault of mine, this has been diverted to U.N.I.C.E.F.

Yours, etc.,

JAMES MANSIE.

112a, Harley Street,
London, W.1.

British Empire Cancer Campaign

SIR,—I write again about the British Empire Cancer Campaign Flag Day, which has so successfully been supported by the nurses and the other Guy's supporters in the past. This collection is now every other year, and will take place at Guy's Hospital on Tuesday, 25th May, the collection starts at 7 a.m., and the volunteers' tins can be collected at the Matron's office the day before by kind permission of the Matron.

Yours, etc.,

ELIZABETH CLARKSON,
Treasurer of the Ladies' Committee,
London Branch of the British Empire Cancer Campaign.

107, Harley Street,
London, W.1.

A Mutter of Tabs, or
A Matter of Tubs

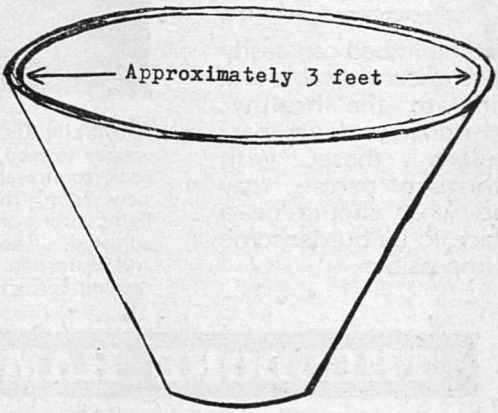
SIR,—As those who saw the last Residents' Play will doubtless remember, I still take an active interest in the affairs of my hospital. It was thus not without concern and dismay that I noticed the sudden appearance of several curious concrete constructions around my person in the forecourt of the hospital. As, of necessity, my personal appearances in the hospital must be rare, and I am obliged to spend the greater part of my time in the forecourt, I would appreciate the removal of these twentieth-century tubs and their replacement by something more in keeping with my original designs.

Yours, etc.,

Thomas Guy.

The Forecourt,
Guy's Hospital, S.E.1.

An Artist's Impression of The Tubs in Question:



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Hamblin

RECUMBENT SPECTACLES

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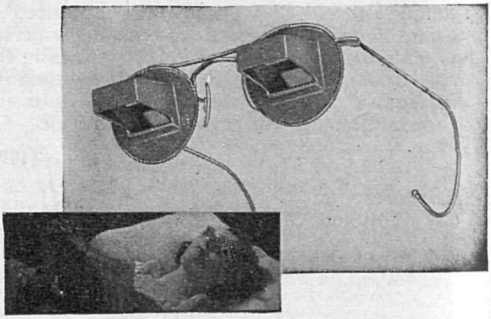
Reading in bed can easily prove uncomfortable and tiring to the healthy; bed-ridden patients, particularly those with arthritis or paresis, may find what should be a solace to be burdensome or impossible



HAMBLIN RECUMBENT SPECTACLES enable the wearer to read, even when fully supine, with the book comfortably propped on his chest. In their new form, these prism-bearing spectacles are light, strong and optically rigid; they are easily adjusted. The prisms are free from chromatism and distortion. Provision has been made for a reading correction to be added.

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SPORT

RUGBY FOOTBALL

Guy's had a successful season, but the success was limited in that we did not win the Cup, and failed to achieve significantly more victories than we did the previous season, winning 12 out of 34 games. However, it would be unfair to judge the success of the season on these figures alone.

The most striking feature of the results is that, although Guy's lost more matches than they won, they scored more points for than against, 356 against 341. These should be compared with last season's when we scored just over 200 points and had 400 scored against. Also, over the past few seasons, Guy's have been tending to score many points from penalties. This season the kicking has been very inconsistent and many more points have come from tries. In only a few games did we fail to score a try, and in six games, we scored four tries or more.

Undoubtedly the best win of the season was the 13—0 defeat of the London Irish, against whom we scored 3 tries. Two other good victories were against United Services (Portsmouth) and Buckinghamshire. We soundly beat Bromley, London University, Old Blues, Old Cranleighans, Reading and Old Paulines. Only three sides scored 20 points against Guy's, Aberavon, Bedford and Coventry. These results make good reading. However, against some weaker sides, Guy's failed to produce their form, and we lost eight games in which the difference between the scores was no more than a try or a penalty. Some of these games could, indeed should, have been won. Guy's also put up some good performances against the stronger sides, losing 9—11 to Pontypridd, 8—15 to Richmond, and 5—16 to Gloucester.

The story of the Cup has been well covered. After beating Charing Cross 14—3, Guy's let Mary's in with an 8—8 draw in the semi-final. In the replay, Guy's lost 3—8. The most surprising thing was that Mary's later lost the final to the London.

Undoubtedly one of the factors which contributed to the success of the first team was the strength of the "A" team, who won their Cup, beating St. Thomas's 6—0. In the past, the "A" team has lacked players of 1st team standard, but this year there were several capable of deputising in the first team. This fact also made competition for first name places the keener.

Finally, a great factor in the team's success was the captaincy of Ian Baker, who unfortunately missed the last few games of the season through injury. Struggling at first to find his form, he played three quite outstanding games in the Cup, each time with a broken nose. He has been playing for Guy's on and off since 1958, and has been captain for the last two seasons, and this experience, his knowledge of the game and his wisdom have been a great asset to the team.

CRICKET

The cricket season commences next Saturday, April 24th, with a half-day match against Beckenham at Honor Oak Park. Prospects for the season and a full list of fixtures will be published in the next edition of the *Gazette*.

Reports and Results

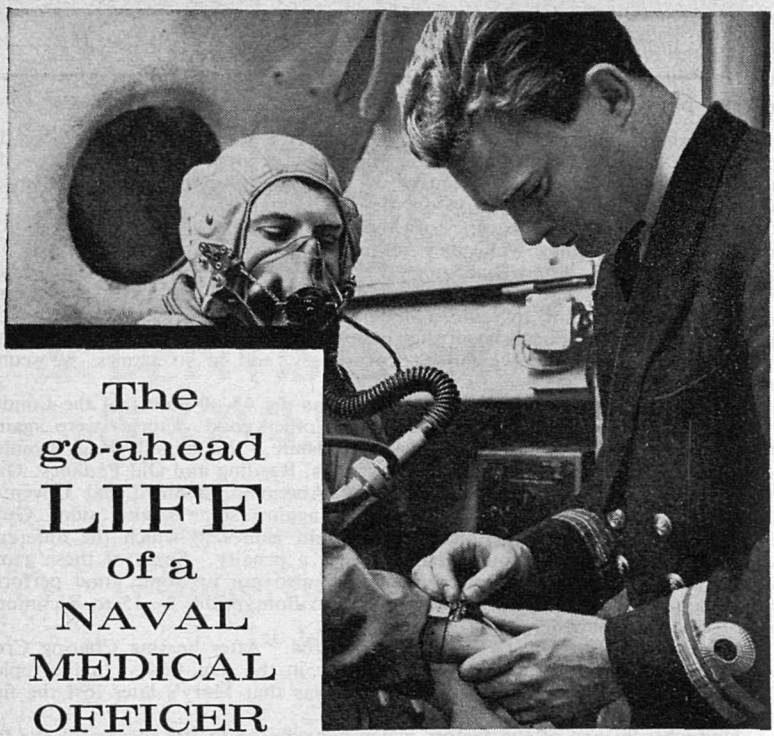
HOCKEY

The season has not been successful in that objectives in October have not been realised: the Cup was lost, and there were more losses (and one more victory) than last year.

However, the Cup was not lost without a struggle, and the eventual joint winners, Bart's, only defeated Guy's 1—0 after four hours 10 minutes play—certainly a good effort, but this was a side that should have been beaten.

The benign weather has allowed a very full Saturday fixture programme, and the performances have been mixed. The better games have generally been won, and the Kingston Grammar School and Tulse Hill fixtures were probably the highlights of the season. Too often, however, the poorer fixtures have been approached too casually and some shoddy performances resulted, unavailability of players not helping matters. Generally the most noticeable feature has been the lack of scoring ability, as the table below shows (14 of these 34 goals being scored in three matches). That more than two goals were scored against the side on only three occasions speaks for the soundness and consistency of the defence, which has been together for three years.

A number of promising freshmen joined the Club, and should find themselves much good hockey in the next few years. Only Cripps was able to notch a permanent place for him-



The go-ahead LIFE of a NAVAL MEDICAL OFFICER

A pilot being prepared for a simulated high altitude test.

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You can enter in one of three ways: as a registered Medical Practitioner — your civilian experience back-dating seniority— or as a qualified doctor doing your pre-registration year, or as a student with a 2nd M.B. For qualified women doctors, there is a special short service commission. For fullest details of your Royal Navy life as a Medical Officer, write, mentioning your own qualifications and age to:

The Medical Director-General of the Navy, Medical Department G066/K, Empress State Building, London, S.W.6.

self in the first team this year, but there should be ample opportunity next year, with a number of stalwarts leaving.

The second team did well and are congratulated on sharing the Junior Cup with Mary's—not *entirely* satisfactory! The Club is indeed fortunate in having a player of Rear's ability playing in goal for the 2nd team. He has put in some fine performances for U.H. (for whom six other Club members have played).

The third and fourth teams again have given tremendous support to the Club and provided the backbone of a most enjoyable season.

Off the pitch the Club has further enhanced its high reputation. There is a fine spirit in the Club as a whole, which is what makes playing for and against Guy's such a pleasure.

Results:

Team	P.	W.	D.	L.	Goals F.	Goals A.
1st ..	24	10	6	8	34	25
2nd ..	17	8	1	8	30	28
3rd ..	17	5	4	8	28	32
4th ..	11	1	2	8	6	32
Wednesday 'A'	9	7	1	1	23	9

GUY'S v. BROMLEY II

At H.O.P. Saturday, 3rd April, 1965

Result: lost 0—1

The final game of the season typified much of the hockey the Hospital has produced this year. The defence was sound, with the forwards good, but unable to provide the finishing touch that is so essential. The forward line was virtually complete, but the defence several players short; and Turfitt, Laing, and Ewing deputised excellently, with the latter producing some fine clearances in the circle.

On a beautiful morning, it was soon apparent that Guy's forwards were in good form, and a number of excellent movements were set up, but with no result. It was obvious that the opponents were no laggards either, and a pleasant battle developed, with no score at half time.

Guy's were not so lively in the second half, but wasted further chances, and fine centres from both wings might well have led to a score. Interchanging the inside forwards appeared to make no difference to scoring ability, nor to general play.

Bromley frequently attacked as well, with their right wing pair causing Guy's defence some difficulty; however, Rear was more than competent in goal. Towards the end, the Bromley centre-forward spun round and crashed home an unstoppable half-volley from the left. Guy's pressed, but still could not score, and a fine game ended with Guy's unlucky losers.

K. E. HAYNES

Team: S. Rear; D. Ewing, K. Haynes; K. Laing, P. Rushmer, N. Turfitt; R. Carruthers, S. Cripps, M. Appleby, P. Bennett, M. Lewis.

INTER-HOSPITALS 6-A-SIDE COMPETITION

At Cobham 4th April, 1965

Guy's dominated the hospitals 6-a-side competition, but allowed St. Thomas's to win. Guy's I comfortably won their league with three good outright wins and conceding no goals. Guy's II also qualified for the semi-finals by being runners-up in their league and scoring more goals than any other team.

Unfortunately, Guy's I and II were drawn against each other in the semi-finals. This produced probably the best match of the afternoon, which Guy's II won by a short corner, each side scoring one goal. In the final Guy's II pushed St. Thomas's to the limit in another fine performance, and narrowly missed scoring on several occasions, thus allowing St. Thomas's to win by one goal.

BOAT CLUB

This term, as far as the 1st VIII has been concerned, has been beset by bad luck. After last term's successful races, the crew looked forward to an equally promising Spring Term, despite the loss of Ian Grimble, who left the crew to row for Leander Junior VIII. Kevin Sonmi joined the eight in Grimble's place at 2, and soon settled down, performing useful work.

The first VIII boat was renovated and put in first-class trim ready for the "Heads", only to be seriously damaged during its second outing by hitting a submerged object at an exceptionally low water. This was a major setback, since the crew was really getting into its stride, despite being coxed by various substitutes during the regular cox's illness. The boat was, in fact, so seriously damaged as to be out of action for the rest of the term.

The arrival of the new blades was some compensation for having to change to a strange and heavier boat, gallantly loaned by St. Mary's, two weeks before the Reading "Head". The blades, being more tulip shaped than conventional spades, proved very satisfactory, and the full crew, complete with navy blue singlets, set out for the Reading University Head, the full report of which follows below.

The following Wednesday was the University of London Head, and the crew, minus Dave Jessett because of flu, with Nick Pinkney rowing instead, arrived at the Boathouse to find the new blades apparently lost by the boat transporters, not having arrived back from Reading.

Thus, the crew, rowing with a scratch set of blades, and a substitute in appalling weather conditions, perhaps have some excuse for dropping seven places from 11th to 18th in the U.L. Head.

Despite such cruel misfortune, the VIII settled down for two weeks hard training for the final event in the term's rowing, the "Tideway Head", and managed two first-class outings, helped by some coaching from Bob Morgan.

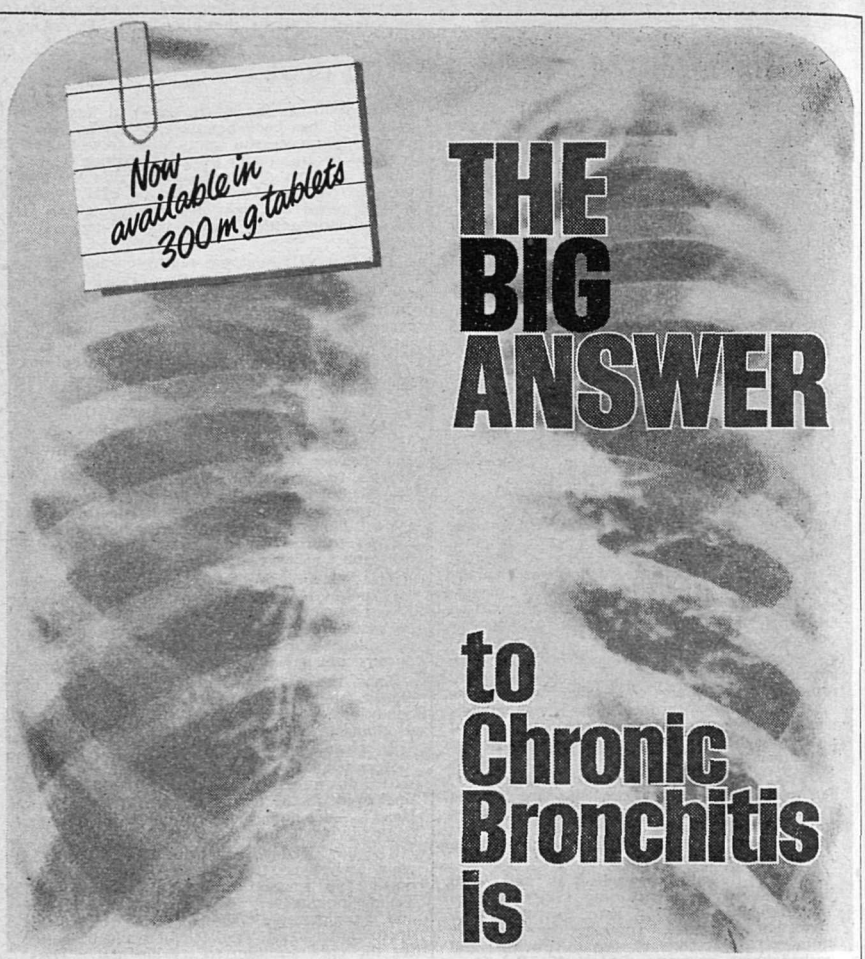
The day of the Head proved ideal, and the crew arrived at Chiswick fairly confident of putting up a good time, only to find Paul Telling looking very ill with a raging headache and a temperature. Despite being told by his doctor not to row, Paul felt it would be better for the crew for him to try his best. Thus, Telling moved back to 2, 2 and 4 moving up one place each on stroke side. Even with these fortunes the crew managed a fairly respectable time of 21 min. 11.4 secs.

Thus, in summary, a term of illness and sheer bad luck. Nonetheless, morale remains high in anticipation of the Hospital's "Bumps" and the Summer Regattas next term.

In contrast, the 2nd VIII, working, as always, with virtually no coaching, have had a most rewarding term, going up in every regatta entered. The success is due mainly to the efforts of John Williams, who has coerced, encouraged, and led his fellows with unfailing enthusiasm despite the usual trials and tribulations of a second eight. With more experience, there is a considerable reservoir of 1st VIII material in this crew.

Finally, as mentioned above, the new blades arrived from Wood's, and have so far proved very satisfactory, despite a tendency to weaken the finish. The new boat has also been ordered from Sims, and should be ready in October.

A. GREEN



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HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL

Applications are invited for the appointment of **Trainee Registrar in the Department of Diagnostic Radiology,** with duties from 1st October, 1965. Appointment for one year in the first instance. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, S.E.1, not later than **1st May, 1965.**

GUY'S HOSPITAL MEDICAL SCHOOL, LONDON

Applications are invited from registered medical practitioners for post of **Junior Lecturer or Lecturer in Department of Pathology.** The lecturer's duties will include Experimental Pathology as well as Morbid Anatomy. Previous experience, although desirable, is not essential. Salary range: Junior Lecturer, £1,400—£1,470; Lecturer, £1,580—£2,535, with superannuation. Application should be made not later than **30th April, 1965,** on a form obtainable from the Dean.

EVELINA CHILDREN'S HOSPITAL OF GUY'S HOSPITAL, SOUTHWARK BRIDGE ROAD, S.E.1.

Applications are invited for the post of **Resident Paediatric House Officer (with casualty duties)** for six months from 1st August, 1965. The Appointment is recognised for the D.C.H. and consists of four months medicine and two months surgery. Candidates must be registered practitioners and should apply giving age, nationality, qualifications (with dates), and copies of three recent testimonials to the Hospital Secretary by first post on **Monday, 10th May, 1965.**

PASS LISTS

UNIVERSITY OF LONDON
M.S.
J. C. Gazet

ROYAL COLLEGE OF SURGEONS OF ENGLAND
L.D.S.
Anatomy and Physiology
D. S. Lewin J. Ballentyne

Special Anatomy and Physiology
A. J. Carr C. M. Doyle
D. S. Lewin

NURSING NEWS

Entered
Sister B. Wreford, to night duty.

Left
Staff Midwife D. Coles—Nuffield House.
Staff Nurse J. Oni-Orison—York Clinic.

FINAL STATE EXAMINATION
February, 1965

Abernethy, A. P.
Aldred, V.
Allcock, G. E.
Barclay, E. H.
Bason, J.
Beale, E. A.
Bendall, P. E. A.
Bennett, P.
Brown, S. J.
Bucknall, R. M.
Bulmer, A. I. L.
Byford, A. M.
Chapman, J. S.
Clark, C. A.
Clegg, F. H.
Crichton, K.
Davies, A. M.
Dun, M. S.
Else, J. A.
Froggatt, E. M.
Groom, M. A.
Hardy, S. M. J.
Hill, A. P. H.
Holcombe, J. M.
Hurt, E. M.
Jenkins, G. M.
Johnson, S. M.
Jones, E. R.
McMahon, J. M.
Miles, P. A.
Mitchell, E. A.
Moody, P. A.
Morgan, G. M.
Morrison, J. M.
Newby, A.
Parker, R. V. H.
Paskins, A. J.
Radford, H. K.
Ramsey, A. L.
Rilstone, B. M.
Sawyer, E. J .
Sheppard, E. L.
Sherlock, C. E.
Smith, P. A.
Stewart, M.
Tweedie, M.
Ward, H. M.
Ward, R. N. S.
Warren, S. V.
Waters, B. A.
Waterson, S. E.
White, G. A.
Winslett, S. E. G.

PERSONAL

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CHANGE OF ADDRESS

Dr. Brian R. D. Murray, 85, Woodland Drive, Hove 4, Sussex.

BIRTHS

ARMOUR.—On 10th February, 1965, at Pine Lodge, Woodhall Spa, Lincs., to Madeleine (née Fairchild, L.D.S.) and Sandy Armour, M.B., B.S., a daughter, Melanie Jane, a sister for Kim and Glenn.

JAMES.—On 2nd March, to Catherine (née Fischer) and Edward O. James, L.D.S., R.C.S., of Llanelly, a daughter.

O'CONNELL.—On 11th January, 1965, to Anne (née Daly) and Dr. Sean O'Connell, of East Croyland, Woodham Road, Woking, Surrey, telephone number 3589 (new address), a son, Hugh Patrick, a brother for James and Clare.

MARRIAGE

STEIN.—On 9th March, 1965, in Auckland, New Zealand, Michael Stein, M.B., B.S., D.Obst., R.C.O.G., to Barbara M. Mehta.

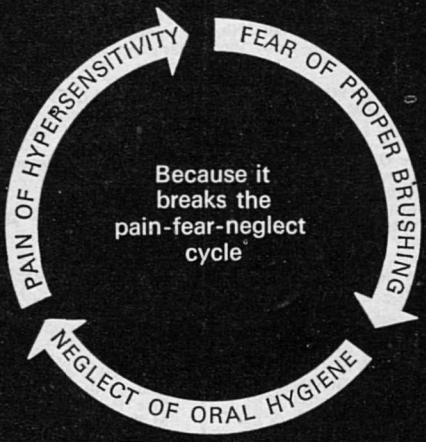
DEATHS

MURRAY.—On 14th February, 1965, at Guy's Hospital, Jean Brown (née Purvis) beloved wife of Dr. Brian R. D. Murray, and mother of Stuart and Douglas.

SAWDAY.—A. E. Sawday, F.R.C.S., died suddenly on the 30th March, at the age of 70 years.

in adjunctive treatment of hypersensitivity:

Sensodyne first


PAIN OF HYPERSENSITIVITY
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NEGLECT OF ORAL HYGIENE
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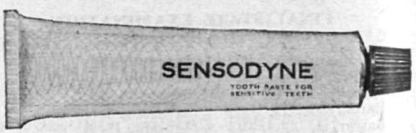
The therapy of choice . . . when apparently normal teeth are sensitive to heat, cold, sweets, acids or touch * the sensitive tooth neck is exposed through surgery or recession * dentine and cementum are exposed through abrasion, attrition or erosion.

Clinical studies on Sensodyne reported in the dental literature (reprints available):
1. Cohen, A.: Oral Surg., Oral Med., Oral Path. 14:1046–52 (Sept.) 1961. 2. Skurnik, N.: J. Periodont. 34:183–185 (March) 1963. 3. Zelman, H. and Hillyer, C. E.: New York J. Dent 33:259–262 (Aug-Sept.) 1963. 4. Ross, M.: J. Periodont. 32:49–53 (Jan.) 1961.



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GUY'S HOSPITAL GAZETTE

FORTNIGHTLY ONE SHILLING VOLUME 79 NUMBER 2003

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EDITORS B. H. HICKS AND P. BOWDEN

SPORTS CORRESPONDENT A. PROCTER

GUY'S HOSPITAL, LONDON

PASSIM

Towards What ?

Some readers have been quick to observe, and some correspondents not slow to remind us, that discussion only too frequently provides a poor substitute for action. Their criticism is directed towards the question of medical education, but they may be further alarmed to see a new series of articles entitled " Towards Better Medical Care", opened by Dr. Ronald Mac Keith on page 203. At first glance, the health service appears to take its full share of verbiage. The stream of suggestions and complaints in the journals' correspondence columns, the neon-bright promises of the politicians with an election near, the Commissions set up to review every part of the structure (except the basic plan), these are perhaps too much with us. Yet below the surface of petty controversy, there is an impressive dearth of radical thought, of fresh approaches.

It is sobering to reflect that throughout the recent explosive phase of the general practitioners' dispute, the thinking and negotiating seemed to be so firmly rooted in the pattern of general practice established in the nineteenth century. Why this tacit and widespread acceptance of a historical tradition, which may have only part of the answer for to-morrow's medical problems? Why is the profession committing itself so unreservedly to a future where the general practitioner is expected to cope with the complete home management of 4,000 or more better-informed patients, many of them geriatric? After almost twenty years of a great medical experiment, the National Health Service, it is a shameful blot on the profession's record that, neither the B.M.A. nor the Royal Colleges have examined the future pattern critically and constructively. Schemes such as the Woolwich and Erith project are but bright sparks of hope where there should be a furnace of ideas; even this project will be forced by its small nature to be essentially conservative. The organisation of medicine in this country should cease to rest on traditional assumptions. It should grow renewed out of a fresh, thoughtful appraisal of future needs and medical resources. The freshness and the thought are in many places long overdue.

The health service is the subject of abuse and contempt, not only from the Medical Associations in many of the other highly-developed countries, but also from within. Some of the criticism is justified, the more so because of the stagnation since its inception, but "the system" must be distinguished from "the imperfections of the system." The imperfections have been tolerated too long and it is doctors who have tolerated them. The system, of social medicine, will be recorded in historical texts of the future as one of those great advances that mark the progress of human society from time to time. The apologies are for the defects, but there is pride for the system. The world and ourselves must be reminded that most British doctors and their patients believe in the ideal and future of their health service; and it is time for them to think and work upon it.

The Status Seekers

Thirty years ago a young man chose Medicine for vastly different reasons than he does so today; it was a way of life. They were often the sons of doctors or from people of a well-to-do background who had a vocation to fulfil. The returns from their work were purely secondary to the inherent satisfaction of being the doctor. Medicine was for the intelligent monied who wanted to do something more than replenish the family coffers.

Today a completely different type of man is clamouring at the doors of admission to the Society of Medicine. More often than not he is from a Grammar School and subsists due to the generosity of the county council without which he could not study. To them it is the means of achieving a position and remuneration which would be denied them in any other work. Now we have the status seekers. Dare we suggest that it is from these ranks that the present dissatisfaction stems. A cause of the present disillusionment could lie in our new type of doctor whose motivation is not of such pure origin. Our Public School fathers accepted a National Health Service which their Grammar School sons cannot continue.

All Guy's men will be delighted to hear that The Colgate Prize awarded annually for the best paper presented at the meeting of the British Division of the International Association for Dental Research by a research worker of the age of 35 and under, was this year won by Dr. T. Lehner, of the Department of Dental Medicine. The title of Dr. Lehner's paper, presented at Leeds on 8th April, was " Autoimmunological Investigation of Recurrent Aphthous Ulceration."

Abbr

In order to facilitate communication, the cult of abbreviation is becoming a discipline in itself. The Obstetrician is quite familiar with his patient's Vx., L.O.A. and F.H.H., and the Cardiologist has A.S.D., P.D. and A.S. On paper, abbreviation of abbreviation can't be far ahead; we may be left with just the top halves of letters or defined spaces, like paintings by Miro.

The natural progression of such a system will lead to the abbreviations evolving into words in their own right, and we will start to chant enigmatic symbols such as " urti ", " ics " and " nad". After that the path to total incoherence is clear. For the more traditional who wish to preserve the old-fashioned idea that communication is necessary, there is a way out of this nightmare of symbols. Instead of abbreviating things and then turning the abbreviation into a word, why not adopt an established system of simple words such as numbers. The poetic simplicity of the word "eleven" would commend itself admirably to describe the condition known as hypogammaglobulinaemia and be considerably less taxing to the tongue.

To conclude, try six thousand three hundred and fifty-nine.

The Rev. A. J. M. Saint has been appointed Vicar of St. Philip and St. James', Oxford, and leaves Guy's early in May. The newly-appointed Chaplain, the Rev. Reginald Beavers, will not arrive until the end of July. Meanwhile the Rev. George Forbes Wilde will be locum tenens.

GUY'S DIARY

MAY.

EXHIBITION.		*Osteomyelitis.*
3rd M.	1.00	Dr. FLEMINGER. Clinical Lecture.
4th T.	1.00	Dr. KENDALL. Clinical Lecture.
6th Th.	1.00	Mr. GLOVER. Clinical Lecture.
6th Th.	1.00	Mr. K. PRINGLE. Dental Clinical Lecture. "*Treated Orthodontic Cases,*" in the Dental Theatre.
7th F.	1.00	Dr. TROUNCE. Clinical Lecture.
10th M.	1.00	Dr. HILLS. Clinical Lecture.
11th T.	1.00	Professor JAMES B. FIELD, M.D., Director of the Clinical Research Unit, School of Medicine, Pittsburg. "*Circulating Insulin and Its Antagonists.*"
11th T.	1.00	Professor W. E. HERBERT. Dental Clinical Lecture. "*Clinical Cases,*" in the Dental Theatre.
13th Th.	1.00	Dr. DOW. Clinical Lecture.
14th F.	1.00	Dr. SCOTT. Clinical Lecture.
22nd S.	10.00	Clinico-Pathological Meeting. Clinical Theatre.
27th Th.	5.00	Neurosurgical Round. Conducted by Mr. Schurr. Clinical Theatre.

COMBINED ROUNDS, SUMMER PROGRAMME:

MAY	
7th	Professor Butterfield, Dr. Leatham and Dr. Deuchar. *Cardiology.*
14th	Dr. MacLean and the South East Regional Board Physicians.
21st	Professor Butterfield and Dr. McArdle.
28th	Dr. Trounce, Dr. Compston and Mr. Boulter. *Chemotherapy of Malignant Disease.*
JUNE	
4th	Professor Butterfield, Dr. Booth and Dr. Langman. *Gastroenterology.*
11th	Professor Ross-Mitchell and the Department of Paediatrics.
18th	Professor Butterfield, Professor Sherlock and Dr. James.
25th	Professor Butterfield, Dr. Bayliss, Dr. Bishop and Dr. Lessof. *Endocrinology.*

The Changing Face of Medical Care

RONALD MAC KEITH

The changes which medicine undergoes derive from the general changes in our society plus certain special effects of these within medicine itself. The present era is one of the application of scientific method and technology. There is an accelerating increase of knowledge, an application of some of this new knowledge, and a discarding of some but not all of the knowledge that has been proved wrong. There is to a large degree full employment and consequent abolition of poverty. The welfare services are more widely available and a higher level of all these services, including education and medical services, is expected.

If medical care is to become better, all the three chief sections of medical services in this country deserve attention.

The Preventive services

Prevention includes primary, secondary and tertiary prevention. Primary prevention is preventing illness happening, by the provision of a good environment, with clear air and good housing; by health education in how to keep well and avoid illness, (e.g. teaching the advantages of and how to get good sleep, and the dangers of and how to avoid venereal disease); and by provision of active protection against certain specific diseases, e.g. diphtheria, tetanus, pertussis, poliomyelitis, smallpox, tuberculosis, measles.

Secondary prevention is the early recognition of illness at a stage when a complete cure and prevention of recurrence can be hoped for. This can be achieved for example by noticing all squints in children over the age of 6 months and getting an ophthalmologist's help; by regular cytological examination to detect cancer of the cervix of womb; by regular periodic radiological examination of the chest; by periodic routine examination of infants, school children and adults.

Tertiary prevention is dealing with chronic handicap to prevent the development of further handicaps secondary to the original ones and to teach the handicapped to live with their disorders, their diabetes or cerebral palsy, etc.

Everyone can contribute to preventive care; by the example of not smoking cigarettes, or by persuading those who have a symptom to get it investigated *and* persuading them to take suggested treatment. All doctors have special preventive responsibilities. In addition in each area one doctor, the medical officer of health, is very

This article is based on a lecture originally given at Goldsmith College, in the series "Towards Better Medical Care."

properly given an official responsibility for the preventive and health education services.

The domiciliary consultative and therapeutic services

The person living at home gets his medical care from his family doctor either at the surgery or in his home. The family doctor is directly, immediately and continuously available to the people on his list. The local authority supplements the general practitioner with district nurses, meals on wheels and other domicilary services, including the health visitor. The family doctor can call a consultant to see a patient in the home.

The hospital consultative investigation and treatment services

Hospitals provide a wide service of specialised investigation and treatment services. Patients are dealt with, for emergency needs, in casualty departments, they are referred by family doctors to outpatients for consultation, investigation or treatment; they are admitted if the investigation or treatment cannot be given except in the hospital or if social conditions at home make admission necessary. The National Health Service has made these specialised services available not only in large cities, but in all parts of this country, and has brought modern medical methods to the reach of every doctor and every patient.

Some notable changes in Medicine in recent years

Everyone will pick a different series of recent technical advances in medicine; here is one set:

28 years ago, sulphonamides arrived, providing the first antibacterial drugs for common infections.

25 years ago, rationing ensured good food for pregnant women and for children; a major contribution to laying foundations of good health.

24 years ago, diphtheria immunisation, already known to be good for 15 years, was applied in this country, and within a few years the 50,000 cases and 3,000 deaths a year fell nearly to nothing. (Why was it not done 10 years earlier?)

23 years ago, a better understanding of the steatorrheas.

20 years ago, came penicillin, the first of the antibiotics.

16 years ago, the National Health Service.

15 years ago, the tranquillizers.

12 years ago, drugs for the treatment of tuberculosis.

5 years ago, came the full realization of the relation of cigarette smoking to lung cancer, the death rate of which had risen from 5,000 to 20,000 in 15 years.

In the last few years, operations on infants with congenital heart disease have offered a new way of reducing the infant mortality rate.

Organ grafting is coming in and also a gradual realization of

the contribution of infections of the urinary tract to chronic illness and death.

Changes in attitudes of the public

Medicine is changing not only because of the many new technological discoveries, but from changes in the attitudes of the public and of the profession. Among the public there are:

1. *A greatly increased knowledge and informed interest in learning about medicine.* This has been greatly promoted by Television; by such programmes as " Your life in their Hands " and "Lifeline". Some programmes tend to be on rare and dramatic procedures such as operations on the heart, but more recently programmes have dealt with commoner illness. This move away from treating medicine as "magic" is an important and most desirable step. Television can be used much more, and much more usefully, to promote informed interest in health and growth as well as in disease.
2. *A diminishing fear of illness* and of the abnormal. In the last 15 years it has become respectable to have a spastic child; there is still need to put over understanding and sympathy for mental retardation and to put over that cancer is often curable.
3. *A diminishing fear of doctors* perhaps. Certainly there is some increased tendency in recent years to sue doctors in the Courts.
4. *An increasing realisation that the public can play a part against illness.* This is shown by the various "illness societies" for diabetes, epilepsy, spastics and the mentally handicapped, and secondly by societies such as the " Patients' Association". The " Mother's Care of Children in Hospital " groups collect and disseminate information and tactfully approach hospital doctors and management committees, and are doing thoughtful and useful work.

Changes in attitudes of doctors

Among doctors there have been changes in attitude, too.

1. At the inception of the N.H.S., the local authority health services lost all their hospital beds and the doctors were put on a lower rate of pay than hospital consultants. They are regaining the self respect they lost then and, especially in relation to the observation of the development of young children, are in many places doing good work in new fields.

2. Because his training as a student tends to over-emphasise the part of specialization in medical care and because general practice appears frustratingly different from what he feels he has been trained for, the general practitioner may be discontented. Discontent may also arise because he reaches his maximum income soon after entering practice. A fairly large proportion of the doctors trained in our schools go abroad. But there is no doubt that in the last 15 years the status and self respect of general practitioners as a group has risen. General practice is now viewed as a special branch of medicine, specializing in integrating the various aspects of the

care of the patient and in mitigating the harmful side-effects of specialization.

3. The hospital doctors have become more specialized and perhaps more inclined to draw their satisfaction from being members of a competent team than from contact with patients. There is a new feeling that each hospital must be a teaching hospital for all the doctors of its area.

Paediatrics has changed more than any other basic branch of medicine. The disorders of nutrition of 20 years ago have almost gone and many of the infective diseases are far less severe. The paediatrician gives his time to:

1. The newborn infant.
2. Previously neglected disorders; congenital heart disease, cerebral palsy, mental retardation.
3. Common disorders: asthma, periodic syndrome, etc.
4. Rarities, old and newly discovered.
5. Children with chronic handicaps.

Paediatrics draws on general medicine and in return it can give, to medicine as a whole, its special interests :

1. *In growth, and learning to recognise health and the range of normal variation.*
2. *In prevention.*
3. *In a comprehensive approach* which considers the multifactorial origins and the many aspects of the management of disorders. Paediatrics has no monopoly of this comprehensive approach, but because the influence of mind and environment on the child is more obvious, the general practitioner and the paediatrician tend perhaps to use this approach more than does the specialist.
4. *In measurement and prediction.* Children are growing; there are many dimensions that can be measured. (It is often in doing paediatrics that the student learns about percentile and standard deviations). Because in childhood the foundations of adult health are being laid down, all who deal with children carry a heavy responsibility for the health of the children *and* of the adults these children will become.

In one series of adult patients in a general hospital, it was found that 59 per cent. had diseases in which mental and emotional factors were of primary importance, that " the combination of emotional insecurity in childhood and psychological stress in adult life seemed to be a common and potent cause (of illnesses in adults)" and "while a great deal of ill-health can be prevented by further improvements in the physical conditions of life, it is becoming clearer that further substantial advances in preventive medicine (of illness in adults) will depend as much if not more on improving the mental and emotional environment especially in childhood" (Pemberton, 1951). Paediatrics has a unique newly emergent role compounded of growth, prevention and the comprehensive approach. In relation to these chronic illnesses of adult life so characteristic of western society, it

will, with the family doctor, have a major responsibility to play, in long term preventive medicine.

Future Trends in Medicine

a. *Research.* There is need for giving support not only to gifted work, but to seeing that problems are tackled. In the war, problems were tackled. To-day we need much more research on common illnesses, on their natural history from childhood into middle age, on prevention, on the quality of medical care, on methods of administration.

b. *Study of Expenditure.* The new discoveries imply that more lives *can* be saved, but only if more and more money is spent. Would money be better spent on solving the problems of kidney grafting or on finding how to diminish the deaths from chronic renal failure. Kidney grafting is glamorous and money is certain to be found for it; money should also be found for preventing chronic infections of the urinary tract.

3. *Interest in the quality of care.* This is further dealt with below.

4. *Greater attention to prevention and treatment of mental illness and mental retardation.*

The maintenance of Professional Standards

The N.H.S. was essentially revolutionary rather than evolutionary because it took away monetary success as the essential—though not the only—underlying stimulus and criterion of success in practice. We now have the problem of maintenance of professional standards in a non-profit-making organisation. In a public service, public opinion must be the long term determinant, but the medical profession, if it is to remain a profession, must be responsible for maintaining standards by education, self-appraisal and self-correction. The public will decide what standards it desires and what it is prepared to pay for. At present doctors have not enough time, to keep in touch with advances in knowledge, to listen so as to discover the relation of the patient's feeling and environment to his symptoms. Some hospitals are still in the groove of a charity hospital, expecting to deal impersonally with poor people and only with acute illnesses, instead of having adjusted to considering patients as sentient anxious people, and to chronic handicap and degenerative illness as properly the bulk of the hospitals' work. Because too many doctors still use the way of telling the patient rather than explaining to him in a less authoritarian way, too few patients follow their doctors' advice.

Medical education needs to teach more about the multifactorial origins of disease—to get away from one symptom, one disease, one treatment—and more about how to mobilize all possible ways of helping. The assessment of quality of care needs to be a subject for the student to study; the " medical audit", the other ways of evaluating the work doctors do in hospitals, and the professional mechanisms needed to respond to the findings of the "audit". An interest in quality and results of care will greatly help to maintain professional

standards. Professional distinction, monetary awards to individuals, central direction will also play their part. Above all, more doctors are needed. If the public is prepared to pay for more doctors, the mechanics of producing them can be solved and a better service obtained. Doctors need more help, from secretaries, social workers as well as from nurses. A better National Health Service in local authority, domiciliary and hospital services will come only if public opinion, at all levels, insists on it. Private nursing homes divert the attention of influential people from the need to provide money for improving the hospital and other sections of the National Health Service.

What sort of a service of medical care should be aimed at ?

There is need for a service in which prevention plays a bigger part than it does to-day. This implies better education of the public in biology, the scientific attitude, in attainment and preservation of health. It implies improvement of the environment physical and social. It implies a service in which medical care is more consistently comprehensive in its approach to the origins and management of diseases, a service which studies the results of its efforts. It implies a service which spends some time explaining itself so that the public can understand what is reasonable to expect and what is unreasonable to expect of medical care.

MISS MOWER WHITE *An Appreciation*

Miss Mary Mower White retires from Guy's at the end of April, and on the 21st of the month she completed 40 years at the hospital. Throughout this time she has worked in the Superintendent's Personal Office, of which she became the senior secretary, and took charge in 1960. She has hardly ever been away through sickness, and has happily worked long hours in the devoted service of the Hospital.

By nature quiet and reserved, Miss Mower White has always been a shrewd observer of the Hospital scene, and has been well-informed on many facets of feeling and opinion in the different sections of the community. Apart from the four Superintendents, Sir Herbert Eason, Professor T. B. Johnston, Mr. W. D. Doherty, and Mr. J. B. Blaikley with whom she worked closely, there have been many others, of the medical staff in particular, who have been greatly indebted to her for much willing help over the years; in particular, the honorary secretaries of the Medical and Dental Committees have relied on her greatly, both in the actual carrying out of their duties and in her ability to keep details of long past meetings and their decisions in her mind, readily available when relevant to current discussions.

Miss Mower White, together with Miss Powell, who also leaves after many years of service to Guy's, are going to live in Cornwall, where they have a cottage near Mawgan Porth, and where we hope they will have a long and happy retirement.

AN UNUSUAL CASE OF
ACUTE HYDROCEPHALUS

J. C. Robertson

Geana M., an infant aged five months, was admitted one evening in January, 1964, to the Evelina Children's Hospital under Dr. R. C. Mac Keith. She had been well until a fortnight earlier, when she had been treated with penicillin for a cold. Following this she lost interest in her food. For four days before admission she had been vomiting three or four times a day, and had passed but one motion. Her mother thought that she had severe colic with the vomiting because she "jumped", or had single generalised "jerks" of the whole body. Over the last forty-eight hours her head had grown noticeably larger.

There was a very strong family history of tuberculosis. Her father was being treated for it at the time of her admission. He had open pulmonary tuberculosis while he had cared for Geana for two months after her birth, while her mother was still in hospital. Her sister, aged five, had had an "unsatisfactory" chest X-ray at the same time as her father's disease had been diagnosed, three months before Geana's admission. She was treated for tuberculosis and her X-ray had become "satisfactory". The family had lived in a house in which an adult and two other children had recently been found to be tuberculous. Geana's Mantoux test had twice proved negative before B.C.G. vaccination had been carried out one month before admission.

On examination she was a well-nourished, five-months-old coloured infant, but was "ill, fractious and irritable": her head was obviously enlarged, to a circumference of 20¼ins. (normal *ca* 17ins.), her eyes were wandering, and she had a most peculiar cry. This cry could occasionally be provoked by the slightest jolting of her cot or by noise, but equally often it was spontaneous, starting after several minutes of sleep and accompanied by little in the way of movements. When awake, she responded to noises and could follow the examiner's head with her eyes. When handled she cried continuously and resisted movement strongly. Her skin showed no rashes or petechiae. Her head showed marked widening of the sutures and the anterior fontanelle was raised and tense. She was apyrexial but had marked neck stiffness. Her pupils were equal and reacted to light, and the tone in the limbs was considered normal. Her fundi showed deep physiological cupping, and Dr. MacKeith thought that there might be two early choroidal tubercles in the right fundus. Examinations of all systems revealed no other abnormalities.

In summary, this was a five months infant with a story of a few days vomiting and neck stiffness. These indicated a state of acute meningism, i.e. meningeal irritation. There was also rapid increase in the size of the head.

The causes considered as possibly underlying the meningism were an acute suppurative meningitis modified by an inadequate

course of penicillin or tuberculous meningitis. The rapid increase in size of the head was thought to be an accumulation of c.s.f. from blockage associated with meningitis or possibly a subdural haematoma.

A blood count gave the following result:—

Hb. 89%, 13.9 G/100 ml.,
W.B.C. 9,000/cu. mm.
(74 % polymorphs and 26% lymphocytes).

The chest X-ray was clear, there being no sign of miliary or hilar gland involvement. Subdural taps produced no fluid, so the possibility of a subdural haematoma was ruled out.

This was followed by ventricular and lumbar taps. The findings were:—

	Ventricular c.s.f.	*Lumbar c.s.f.*
Appearance.	Clear, colourless.	Blood stained; xanthochromic supernatant.
Pressure in recumbent position.	Much increased.	> 200 mms. of c.s.f.
R.B.C.	50-60/cu.mm.	5,500/cu.mm.
W.B.C.	8/cu.mm. (80% lymphocytes).	68/cu.mm. (90% lymphocytes).
Glucose.	58 mgs./100 ml.	15 mgs./100 ml
Protein.	15 mgs./100 ml., no excess of globulin.	70 mgs./100 ml., slight excess of globulin.
Chloride.	No estimation was made.	

Gram and Ziehl-Neelsen staining revealed no organisms, nor did subsequent 40-hour culture.

The relatively small increase in the numbers of white cells and the fact that the majority of these were lymphocytes precluded the diagnosis of a pyogenic meningitis.

The possibility of tuberculous meningitis, thought throughout to be most likely, was reviewed. There was much to suggest it: lengthy exposure of an immunologically weak infant to an infectious patient; meningism, enlarging head, lymphocytes in the c.s.f., and the possible presence of two early tubercles of the choroid.

Treatment for tuberculous meningitis was immediately embarked upon. Dr. J. Lorber, of Sheffield was telephoned for his opinion on the diagnosis and the treatment. He agreed that the disease was most likely to be tuberculous and that the blockage of c.s.f. circulation was at the tentorial opening.

Later, Mr. P. H. Schurr saw the child; he found bilateral VI nerve

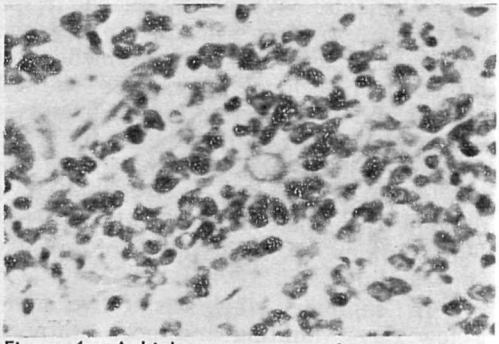

Figure 1. A high power view of the infiltrating tumour cells, demonstrating one of the characteristic rosettes with eosinophilic strands linking the cells to a 'hub' of the same material. *Haemalum and eosin stain. X 520.*

palsies and a stiff neck, with reflexes indicating decerebration. There was no focal abnormality. He agreed that the cause was almost certainly tuberculous meningitis with a basal cistern block. He believed that the c.s.f. analysis confirmed a lack of immunity. He did not think there was an indication for surgical or radiological intervention.

The infant was treated with hydrocortisone and local as well as systemic anti-tuberculous therapy, but some thirty-six hours later, after a restless night with frequent vomiting of small quantities, she was found dead.

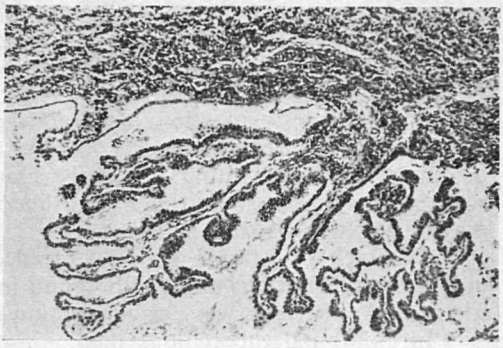

Figure 2. From the roof of the IV ventricle, showing heavy infiltration by tumour of the tissues to which the choroid plexus is attached. *Haemalum and eosin stain. X 109.*

Figure 3. Tumour cells (L) bridging a cerebellar sulcus. The sulcus is lined by Obersteiner's layer of cells, a layer whose persistence into later childhood occurs in cases of medulloblastoma, and from which the malignancy may arise. *Haemalum and eosin stain. X 87.*

At necropsy (Guy's Hospital, P.M. No. 62/64), a diffuse mass filling the IVth ventricle, with consequent internal hydrocephalus was found. The histological examination showed it to be a medulloblastoma (Figs. 1 and 2). The tumour had involved and destroyed the base of the brain as well as spreading throughout the subarachnoid space (Fig. 3). Other findings were flattening of the sulci, turbidity of the subarachnoid space about the base of the brain, and severe pitting oedema of the legs up to the knees.

Discussion

This was a clinical problem of a five-month-old infant with acute hydrocephalus and meningism. The symptoms and signs produced by pathological processes are often modified by extreme youth, and the evolution of the processes is often more rapid. Intracranial tumours are usually thought of as being slow in onset; but in infancy they may present as acutely as did this medulloblastoma.

Hydrocephaly may come on suddenly from a final blockage where there is a congenital anomaly in the pathways or flow of the

c.s.f. The presence of meningism made this inadequate as an explanation of the child's illness.

In retrospect, certain points are remarkable. The two negative Mantoux tests done after the contact with tubercle were good evidence against tuberculous infection. It would have been possible to acquire a tuberculous infection shortly before the B.C.G. was given, but usually the child awaiting B.C.G. is removed from contact with the source of infection. In extremely ill tuberculous patients the Mantoux may be negative—a state called anergy.

The lack of pyrexia and the rapid onset of hydrocephaly were unlike the tuberculous meningitis found in older children, but thought to be explained by a very poor reaction to the infection, i.e. anergy.

In childhood tuberculous meningitis is the most common cause of death in tuberculosis. It may be the terminal event in generalised miliary tuberculosis, but "it may be the initial and only clinical manifestation of tuberculous infection, although it is always a secondary lesion" (Nelson 1959). The c.s.f. in tuberculous meningitis shows a lymphocytic pleocytosis, as was seen here. However, although the ventricular fluid and the lumber c.s.f. were abnormal the increase of protein was insufficient and the sugar content fall in was too great to be compatible with a tuberculous meningitis. Furthermore, tubercle bacilli are found in Ziehl Neelsen stained films made from the centrifuged deposit in the majority of cases of tuberculous meningitis, and the white cell count of the lumbar c.s.f., although raised, was unusually low for tuberulous meningitis.

Routine examination of the cells did not suggest malignancy, but they were not looked at with this in mind for the clinician himself had not suspected this. Had it been thought that the cause might indeed have been a malignant tumour, a correct guess that it was a medulloblastoma would have been hazarded, for it is known to be a most common malignant brain tumour of the first decade of life. It would have been reasonable, while awaiting further evidence, to initiate treatment for the alternative possibility of tuberulous infection and perhaps to have started radiotherapy.

(Other possibilities seem to have either been excluded or to offer no hope from treatment.)

Dr. Mac Keith adds that this case points a number of morals:—

1. That the result of a Mantoux test should never be ignored without earnest consideration.
2. That meningeal reaction may be caused by tumour disseminations as well as by infection, pneumonia, intracranial bleeding, etc.
3. That when the laboratory findings are not compatible with the provisional diagnosis, discussion with an experienced clinical pathologist can be very rewarding.
4. That when an observer expects to see something, he may see it even when it is not there; in this case, "very early tubercles in the choroid".
5. That even when several experienced clinicians agree, their diagnosis may be wrong.

Summary

This is the case history of a five-month-old coloured infant who presented as acute hydrocephaly. It shows how the clinician in charge arrived at his diagnosis and concludes with a list of the salutary lessons drawn by the clinician from his experience of the case.

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ACKNOWLEDGEMENTS.

To Dr. R. C. Mac Keith, at whose instigation this article was written; to Dr. S. J. de Navasquez for permission to quote from the autopsy report and to photograph the histological slides; to Dr. G. A. K. Missen and Dr. A. L. Jeanes for their advice; and to Miss Rosemary Hogg for her secretarial help. Dr. M. Jenkins of the Bermondsey Medical Mission, 44, Grange Road, S.E.1, referred the patient.

JENKIN HOWELLS

Jenkin Howells died at his home, Penarth, Glamorgan, after a short illness on 24th March just a month before his 90th birthday. He qualified at Guy's Hospital, M.R.C.S.(Eng.), L.R.C.P.(Lond.), 1899, and he obtained M.D. (Brux.) 1st class honours, 1903. He was always "The Doctor" and at all times he upheld the best traditions of Guy's Hospital and the medical profession. He never liked General Practice, most of his professional life was spent as part-time Ref. Ministry of Health (Welsh Board of Health). Chairman, National Service Board, at Newport, Chairman, Medical Board Ministry of Pensions, Wales Region. He served as Captain, R.A.M.C. in World War I, 1914-1918. I feel sure that all Guy's Men and his professional colleagues will join me in extending our very deep and sincere sympathy to his wife and his family.

CLEMENT GRANT SPIRIDION-KLISZCZEWSKI

Clement Spiridion, as he was known, and affectionately by his friends and colleagues as either Clem or Sprid, passed away suddenly on 14th April, 1965, in his 85th year. Grandson of a Polish immigrant, born in Cardiff in 1880, he was educated at Chatham House College, Ramsgate, qualified Licentiate in Dental Surgery of the Royal College of Surgeons, England, from Guy's Hospital, London, in 1904, and returned to his birthplace, where he became a very respected and successful General Practitioner in Dental Surgery. In 1923 he was appointed Hon. Dental Surgeon to the Cardiff Royal Infirmary and retired in 1946, but remained in close touch with the Hospital until his death. He joined the British Dental Association in 1904 and was an active member of the South Wales and Monmouthshire Branch holding all offices, including President in 1923, and Hon. Secretary, 1925-1936. In 1952 at the Annual Meeting in Cardiff, he was honoured by being installed as President of the British Dental Association, and held this office conscientiously and with all dignity. In 1948 he was elected a Fellow of the Faculty of Dental Surgery of the Royal College of Surgeons, England. His hobbies included foreign travel, riding, fencing, and amateur dramatics. His life's work was centred around the establishment of a Dental School in Wales, and his ambition was fulfilled when he attended the Induction Ceremony of the first pre-clinical students of the New Welsh Dental School in Cardiff in October, 1964. He was a founder member of the Guy's Hospital Society, South Wales and Monmouthshire Branch, and was President for 1953/54, and attended every dinner, including the one on 13th March this year. During the last war, 1940-1945, he was Polish Consul for Cardiff and South Wales, and both he and his wife did valuable work for Poles in the area, particularly those in hospital. He was a great linguist, speaking five languages fluently, and was one time a prominent member of the Anglo-French Society in Cardiff. He will be very sadly missed by his many friends. He leaves a widow, a son and a daughter, to whom we extend our deepest sympathy.

CORRESPONDENCE

Beyond Thought

SIR,—General practitioner readers of Professor Butterfield's article on the medical curriculum of the future may have noted that instruction on the tidy and lawful disposal of the dead body is no longer felt necessary. Guy's patients, by tradition of course, simply fade away: the ward cupboards, lift shafts and underground culs de sac are noticeably tidy and clean smelling.

Unfortunately this tradition is not general: death, sometimes violent, sometimes merely mysterious, comes to most of us in the end, and the law still demands the trained skills and services of a doctor in the accurate certification and tidy disposal of the dead body.

Professor Butterfield may care to contemplate a charming "Hymn for a Funeral", by John Wesley—found in a tattered Victorian booklet in a country mortuary in 1942:—

" Ah, lovely appearance of Death,
What sight upon earth is so fair.
Not all the gay pageants that breathe,
Can with a dead body compare.

With solemn delight I survey
The corpes when the spirit is fled.
In love with the beautiful clay,
And longing to lie in its stead."

No, Sir, the omission of instruction on "What to do with a Dead Body" might well be a most serious omission. The doctor in practice is still expected to be a practical man.

Yours, etc.,

KEITH SIMPSON.

Department of Forensic Medicine,
Guy's Hospital, S.E.1.

Thoughts on Action

SIR, Thoughts on thoughts on education; the time seems appropriate to begin. My first thought and hope is that the sequel, thoughts on thoughts on thoughts on education will never appear in your columns. The cloud of vacillation seems well settled in medical circles at this moment; not only concerning education. The question "Do we know what we want?" is very properly asked. We have talked about teaching machines and tutorials; theories about the correct mixture of spoon feeding and providing pegs for thought. Examinations we now know are an inheritance from the Chinese Imperial Service (during the T'ang and Sung dynasties) and some people would like to see a three-year degree course in human biology replacing the present 2nd, M.B. I was interested to read the suggestion in the last edition of the *Gazette* that we may have a fully integrated course involving earlier contact with patients. This also lengthens the student period and provides an alternative to increasing the academic part of the course.

It is healthy that medicine should attract people of diverse character and abilities. However, one sometimes wonders whether they really have the same purpose in mind when they come to a medical school. Back again to the problem of what are we trying to produce. We can only hope that in spite of these difficulties some definite plans will come from the discussions shortly to take place here at Guy's. We have our opportunity for change; let us *all* make a united effort to achieve something positive as quickly as possible.

Yours, etc.,

WILLIAM HUGHES

East Wing,
Guy's Hospital Medical School,
London, S.E.1.

Thoughts on Thoughts

SIR, In the series of articles in the *Gazette,* the only point of agreement is that reform of Medical education is necessary. Controversy rages over the form this change is to take. For example, two of the views seem to be diametrically opposed: Professor Sir Charles Illingworth thinks the course is too long, whereas Professor Butterfield would like the course extended.

Medical education at present aims to convert a schoolboy into a doctor. This is the labour of a lifetime. A doctor, we are told, is always learning. Each generation is assumed to need longer education to catch up with predecessors, an assumption borne out by the more arduous conditions applied before a candidate may enter final examinations, e.g. F.R.C.S., and by the greater number of qualifications required in specialties. Finally, one can envisage the situation where half the medical profession is busily engaged teaching the other half, and so on ad infinitum—the Parkinsonian spiral of unchecked science.

Training at medical school should provide a basic grounding sufficient for the young graduate to be allowed out, with safety, into elective practice. He will then let his skills develop while he pursues his chosen occupation, incidentlly accommodating himself quite naturally into the changing pattern of diseases and our knowledge of them in our community—a thing no detailed education can provide for. This is essential if full manpower is to be available for the population to receve adequate medical care. Any person who so wishes could delay qualifying to do an extra course, e.g. the B.Sc. as at present The general practitioners who give at least 75 per cent of medical treatment could then start work, leaving the more academically minded to specialise, receiving more advanced training at the large teaching hospitals. Learning could be combined with work in the junior hospital grades as at present.

The medical curriculum under this system should cover the basic principles of Physic occupying no more than four years from first Physiology lecture to final Surgical viva. This demands a large number of good teachers and a wealth of clinical material. One way of achieving this in 1965 is to move Guy's, with its teachers, to a more populated area outside central London, as is planned for St. George's. The alternative is to move segments of the student body out into peripheral hospitals or "general practice areas" for a time, where basic principles can be integrated with clinical findings. This has two advantages, giving the student simpler problems to which to apply his knowledge rather than the clinical oddities which seem to filter through to Guy's, and also giving him a larger variety of these problems. A General Practitioner Teaching Unit could be used for one month each clinical year to give experience of 800 patients (not "symptom decisions") compared to the 40 or so seen in a month at Guy's. Only in this way can a true picture of the natural history of disease and its treament be learnt.

At present a newly-qualified doctor becomes a houseman with heavy responsibilities, including, for example, the discharge of patients. If he has not seen patients in their own homes and the problems they face there, he is not truly qualified. Weeks with General Practitioners are well spent; surely there should be many more—not less.

Yours, etc.,

A. M. MORRIS

Medical School,
Guy's Hospital, S.E.1.

Still Thinking

SIR,—As a member of the Students' Education Committee, I was particularly interested by the articles from Professors Hunt and Butterfield.

The teaching method of the former is not unknown to many of us; he has not been slow to put his ideas and principles into practice. I and many of my colleagues may have complained of the seemingly extra burdens placed upon us by the "ordering of thoughts" and the "provoking" of them. However, Professor Hunt's points illustrate an important basis for Material Education: that

the student should not have material handed to him "on a plate", but should be encouraged to learn a certain amount for himself and to participate in "feed-back" discussions with his teachers.

In his article, Professor Butterfield extended this basis into clinical teaching by advocating mid-day medical and surgical case conferences, "integrated symposia" and, most important, tutorials conducted by personal tutors. The accent should, in my view, be placed on informed participation by the student. Further, these tutorials and conferences should largely replace, at most be supplemented by, formal ward rounds, the value of which has often been disputed.

Yours, etc.,

J. D. STEPHENS.

The College,
Guy's Hospital, S.E.1.

Amphorae

SIR,—A few years ago I spent a night in the archeologists' guest bungalow at Perrepolis. My bedroom, hard plank bed and one blanket, opened on to a paved colonnade along which were set numbers of amphorae, some very large, some smaller, in several graceful and beautiful shapes. It seems a pity that after nearly 3,000 years, Guy's cannot design bowls, tubs, pots, call them what you will, as graceful as those made by the craftsmen—potters of King Darus' day for use and decoration about his palaces and buildings. These peculiar funnel-shaped objects in concrete do not please the eye, nor would they please the roots of shrubs, if that is their purpose. Can we not do something better?

Yours, etc.

EMILY P. MACMANUS.

Matron's House,
Guy's Hospital,
London, S.E.1.

Sister A. Falwasser

SIR,—I know that a considerable number of *Gazette* readers still intend to sign Sister Job's book and leave a donation towards the gesture which is being collected from many of her friends, since my letter of January 25th appeared in the *Gazette* earlier this year. May I remind your readers that this opportunity will close on Saturday, May 15th? Intended remaining subscribers should please make haste forthwith! Cheques should be made payable to Guy's Hospital and despatched to me personally with a clear signature written on a separate piece of paper which may then be affixed into the appropriate book accordingly.

Yours, etc.

ANNE M. JOHNSON.

Matron,
Guy's Hospital.

REVIEWS

DISEASES OF WOMEN.

by TEN TEACHERS. Edward Arnold Ltd. 11th Edition. 1964. Edited by F. W. Rogues, S. G. Clayton, T. L. T. Lewis. Pp. 576. Figs. 209. *Price* 50*s*.

Ten eminent London gynaecologists and obstetricians have combined to present this new edition of the Ten Teachers test-book of gynaecology. Different styles and approaches are apparent on reading the book, and it would be interesting if there were some indication of who is responsible for each chapter, but in spite of the multiplicity of authorship, the book fits together well.

It starts with sections on the relevant anatomy, embryology and physiology. These sections are rather dogmatic and not very stimulating, but will doubtless be very useful for reference. Next follows a large clinical section, classified according to diseases. The descriptions are very good and are greatly clarified by the use of headings, "SIGNS", "SYMPTOMS", etc. Perhaps some vertical listing would make the text even clearer. The suggested therapy is up-to-date, but there is a tendency to treat the disease as a separate entity and to forget that the patient is a woman with emotional, social, moral, and spiritual facets. This is especially so in the chapter on venereal diseases. There is, however, one short, separate chapter on psychosomatic disorders. One small omission, I could not find any explanation of the grading of cervical smear cytology.

There is a useful summary of clinical material, classified under symptoms, and very good sections on surgery and radiotherapy. The descriptions of operations are especially lucid and helpful.

The book as a whole is a good, clear comprehensive text-book, for the student or practitioner. It sets out to be useful rather than entertaining and in its 571 pages it certainly contains a large amount of information, tidily arranged. The numerous illustrations are excellent and help to make the book a valuable asset.

JOY LAWRENCE

UNDERSTANDING YOUR SYMPTOMS—A LAYMAN'S GUIDE,

by Joseph D. Wassersug, M.D., Abelard-Schuman, London. *Price* 35*s*.

If preventive medicine and early diagnosis are accepted as goals, patients must have a greater knowledge of how their bodies function in health and disease than they possess to-day. The question is, how shall they obtain it?

Dr. Wassersug has written a book based upon many contributions to a column in an American national newspaper. The book explains carefully and without sensationalism what all the common symptoms and symptom complexes may mean, in pathological terms. The detail given is considerable, to British eyes at least. In general, the factual information is accurate, although the emphasis is sometimes oblique to British practice.

The only test a doctor can apply to this book is: would I like my patients to have read it before they consult me? With regret, I think the answer is No. This is a pity because there is considerable good in the book. If all patients had read the first two chapters, "How to understand your symptoms", and "How symptoms are described" practice would be considerably easier. I feel that a book describing fully, but in non-technical language, *normal* function and linked to an expansion of these all too brief chapters would be a valuable contribution—much more valuable than the catalogue of detailed symptom interpretation that Dr. Wassersug has given us. No one would plough straight through the book—is it intended for reference when the person begins to suffer from a symptom? It would be of help in determining whether or not the patient should consult a physician, but unless he is a hypochondriac, if it is bothering him that much he should probably see his doctor in any case.

Explanation of symptoms in detail needs to be tailored to *the individual situation* in every case, from physician to patient. Perhaps it is a comment on the fact that, as doctors, we allow so little time to find out what symptoms or illness may mean *to our patients* that Dr. Wassersug has found a popular demand for his column, and a need to compile this book.

J. S. CAMERON.

HANDBOOK OF OBSTETRICS AND GYNAECOLOGY.

by RALPH C. BENSON. Lange, 1964. Pp. 656. *Price* 37/6.

This American paper-book is one of the cheapest combined text-books of Obstetrics and Gynaecology available and is intended as a ready but comprehensive companion for the student, house-officer, and practitioner, rather than as a standard text-book. In general this ambitious aim is well fulfilled; the third of the book devoted to Gynaecology is concise yet contains more than enough material to satisfy the finals examiners, and the illustrations are of a high standard throughout, both in regard to quality and usefulness.

The section on Obstetrics differs from the usual British practice on a number of points, mainly with regard to classification and treatment: in particular, the chapters dealing with the mechanisms of labour and management of eclampsia are inadequate. With this reservation the majority of the chapters in this section are well written, especially those on the management of the puerperium and the Anatomy and Physiology of the Female Reproductive System which are brief while retaining the essential facts.

For these reasons, although this little book is, in general, excellent value for money and would be useful as a ready pocket companion, it cannot be recommended as a student's principal book of Obstetrics and Gynaecology.

PETER DAVIES

BASIC PRINCIPLES OF ACCIDENT SURGERY.

by M. C. T. Morrison. Lewis Pp. 116. *Price* 40*s*.

I have read Mr. Morrison's book with interest, particularly as one of his mentors, Mr. P. Ring, has recently published a book on a similar subject.

In the preface, Mr. Morrison emphasises the relative lack of trauma in the main teaching hospitals and, therefore, aims his book at the newly-qualified House Officer with little or no experience of major trauma.

The book is divided into two sections, the first devoted to the Individual Tissues. In the opening chapter a number of fundamental points are emphasised—the points which we would do well to ponder more frequently. Then follows a series of short chapters on the various tissues; skin, fat, muscle, bone, etc. On the whole these chapters are over-simplified, although they enumerate a number of important principles. This simplification may deter the House Officer—who generally has little time for reading—from reaching the second, and perhaps more interesting section entitled " Clinical Injuries." This opens with a short but very pertinent chapter headed " Multiple Injuries." It contains an excellent list of questions which any person receiving a major accident should ask himself. Next there is a very good chapter on the initial diagnosis and treatment of chest injuries. These two chapters are, I think, the most valuable in the book.

Then follow chapters on shock, abdominal injuries and head injuries; these chapters are clear and informative.

Next there is an account of spinal injuries. This is one of the least good chapters. There is virtually no mention of cervical injuries—a subject which I find is one of the commonest causes of worry to the House Officer. There is also no mention of hyper-extension injuries or of burst compression fractures. The very basic classification here does, I think, result in loss of clarity and usefulness, although the author might reasonably argue that this is dealt with better in standard fracture text books.

One point inadequately dealt with is tetanus prophylaxis—the importance of proper debridement and the use of antibiotics is not emphasised, neither is the doubtful value of anti-tetanus serum. This is the only major criticism I have of the book.

In conclusion, I would recommend all students and House Officers to read this book and, if their time is limited, to read at least the second part. There are very few House Officers who will not find something of help and practical value. It will, I am sure, enable them to bring some order into the disorder which major trauma often presents in the Casualty Department and Accident Ward.

F. J. MOYNAHAN.

NOMINA ANATOMICA,

3rd edition, by the International Anatomical Nomenclature Committee, published by Excerpta Medica Foundation, 1963, *Amsterdam, London, etc. Price* 27*s.*

This expensive paper-backed booklet, though valuable to anatomists, is not for students. Anatomical nomenclature has undergone many changes, as is true of medical nomenclature at large. The book embodies the latest versions of anatomical terms, as agreed to at New York in 1960. Anatomists and clinicians alike may grumble at the efforts of the I.A.N.C., but its worthy aim is the establishment of international uniformity and clarity. In fact, very few terms are involved in sweeping changes in this present edition.

A lengthy and interesting introduction by the Hon. Secretary of the I.A.N.C. (Professor G. A. G. Mitchell, University of Manchester) is followed by the list of terms, in Latin, and arranged upon a combined systematic and regional basis. Since there is no index it is not always easy to find a particular term. A commentary of 23 pages, containing 500 notes, explaining the results of the Committee's lengthy deliberations, is appended. These make interesting and even amusing reading, and they merit a longer review than can be accommodated here. A few points must suffice.

The I.A.N.C.'s punctilio sometimes becomes pedantry. I cannot believe that *hilus* will easily displace *hilum.* Some illogicalities are also patent, and these are too often supported by the unconvincing expression " the Committee felt." The order of terms in the nervous system section is curious: proceeding from spinal cord upwards to brain, the list then goes on to meninges, followed by cranial nerves, descending to spinal nerves.

These are not serious defects, but stultifying changes have been made, as in the lumping together of growth regions, such as synchondroses and sutures, with locomotor joints.

Some trivial structures receive remarkable names, e.g. *ligamentum metacarpeum transversum superficiale,* and *spina frontalis partis nasalis ossis frontalis*! The Committee's taste is also perhaps sometimes questionable, as in preferring vestibulocochlear to statoacoustic as more " euphonious." Surely more cogent reasons could be adduced.

It is a pity that the I.A.N.C. have not taken the lead open to them in promoting such usages as " *vestigium* " for many so-called " ligaments ", for any change which makes terms more significant is desirable. The Committee seem, however, more pre-occupied with the niceties of Latin. In this regard their daring frontal attack on diphthongs is not entirely happy or necessary, though perhaps to some extent a genuflexion to our trans-Atlantic colleagues. The parallel edict—that hyphens shall disappear—is not without its dangers in the formation of a new generation of apparent diphthongs: cf rect*ou*terinei, gastro-epiploic—and what of the plural termination " æ "? Partial rectifications, if such they are and not mere pandering to the ill-educated, are not likely to be much advantage in spelling reform. How is the tyro, without Latin or Greek, to pranounce " tracheae "? A guide to pronunciation of Latin terms would have been a useful addition.

This is an interesting publication, of little use to students, valuable but often disappointing to professional anatomists, likely to make surgeons " see red "! Such a linguistic juggernaut is never likely to progress rapidly; the deliberations of committees rarely do.

R. J. WARWICK.

PLASTIC SURGERY.

by Richard Battle. 1st Edn. Butterworths, London. Pp. 415. Illust. 176. *Price* 97s. 6d.

Mr. Battle, who is the Senior Plastic Surgeon at Queen Mary's Hospital, Roehampton, and the senior pupil of the late Professor Kilner in practice in England today, has performed a considerable service to British plastic surgery by producing this work in one volume. It will become the most authoritative volume on the subject obtainable published in this country. It is a remarkable thing that during the many years that plastic surgery was dominated here, and,

indeed, in most of the world by the work of Gillies and his two senior and chief pupils, Kilner and McIndoe, the published work was undertaken mostly by Gillies. The last ten years have seen the situation corrected with many monographs on different aspects of plastic surgery published here and in America, and, more recently, as the two books reviewed here show, there have been several comprehensive publications in one volume or more. A particularly pleasing aspect of both the volumes reviewed here is that clear, adequate accounts are included on the cosmetic aspects of plastic surgery. An unfair and untrue criticism of British plastic surgery made, with some harmful effect, by one cosmetic surgeon that cosmetic surgery was not adequately covered by plastic literature in this country is today more manifestly false than at the time it was made, and can no longer be repeated. In this connection both books deal with "face-lifts", which many English plastic surgeons always prefer to do rather than to speak about. Conversely, a section which gives special pleasure in a modern book on plastic surgery, is that on fractures of the jaws. Mr. Battle, of course, speaks with exceptional authority and experience on this subject. Plastic surgery largely developed from the happy co-operation which grew up in the first world war between dentistry and surgery, by the conscious efforts of two men, Gillies and Fry—one surgeon, one dentist. Mr. Battle has increased the teaching value of his book by deliberately preferring line diagrams to photographs. These, of course, are excellent teaching material and in their production he has been helped by a number of well-known medical artists. The clear, firm line of Miss Archer, late of Roehampton, now of Guy's Hospital, can be seen with advantage in many of them. An exception to the rule that only diagrams be shown is made in the section on cleft lip, in which he includes photographs of some of his own very beautiful results. The reproduction of one special diagram will give great pleasure throughout the world. This shows a reconstruction of the nose from arm flesh (the Tagliacotius, or Italian Flap method) drawn by Mr. Battle's father, Mr. W. H. Battle, F.R.C.S., of St. Thomas' Hospital, in 1876 of a patient at St. Thomas', under the care of Sir Thomas MacCormack, F.R.C.S. This very early nasal reconstruction might very well have been the only rhinoplasty done in England between the time of Carpue, who described the first done in England, the Indian Forehead Flap, about 1810, and the one undertaken by Keegan at the turn of the nineteenth century. After Carpue's death, of course, reconstruction of the nose virtually died out in England until Gillies refounded the specialty in the care of the gun-shot wounds of the face in 1917 in the first world war. As has already been implied, the book is comprehensive and authoritative. It is an irreplaceable book of reference and will play its part in the education of all future plastic surgeons training in England. As with Dr. Barsky's book, the references in Mr. Battle's are well chosen and comprehensive.

Medical Association for the Prevention of War

It is proposed to hold a Conference at Churchill College, Cambridge, from Friday, 9th, to Sunday, 11th July, 1965, on The Physician and the Prevention of War.

Among those who have accepted invitations to take part are Dr. Brock Chisholm (Canda), Dr. Jerome Frank (U.S.A.), Dr. Banerjee (India), Dr. Lacassagne (France), together with a distinguished list of British speakers. Please make application to the M.A.P.W. Conference Secretary: Mrs. Barbara Edwards, "Downside", Park Prewett, Basingstoke, Hants. Preliminary programmes will be circulated to those interested.

Fison Memorial Lecture

Sir Rudolf Peters, M.C., M.A., M.D., F.R.C.P., F.R.S., will deliver the Fison Memorial Lecture on Thursday, 13th May, at 5.0 p.m. The title of the Lecture will be "Fluoride and its Hazards in Living Systems", and it will be held in the Physiology Theatre.

SPORT

RUGBY FOOTBALL

Guy's rugby season ended on Saturday when we were eliminated in the second of the qualifying rounds of the Middlesex seven-a-side competition at Sunbury. Last month Guy's failed to qualify for the finals of the Oxfordshire Sevens

However, a team of Dental Students was invited to the seven-a-side competition of the British Dental Students' Association in Leeds last week, and won the competition by beating the holders, Glasgow, 15—0, in the semi-final, and Belfast 10—5 in the final.

CRICKET

In spite of a slightly disappointing start, the prospects for the season must still be rated good. The main strength of the side should lie in the depth of its batting, which extends right down the order. We are pleased to wecome Cutler, a fine stroke player, to the side. Although he has been at Guy's for three years, he has previously played for several strong Essex sides, as well as representing the County 2nd XI. Hambleton, who scored a record number of runs last season, now has a house job at the hospital and should be available fairly often. The innings will be opened by the experienced McGregor, who, unfortunately, was injured for much of last season. The strength of the batting is completed by the Club officials, Crafts (Captain), Appleby (Vice-Captain), Silk (Secretary), and Powell-Jackson (Treasurer), all of whom are capable of contributing many runs. As a postscript to this paragraph, which was prepared before the week-end's games, the name of Butchey must be added. A newcomer from the University of West Indies (who play first-class cricket in Jamaica), he opened the innings against Horsham and scored 76—a fine achievement in only his second game in this country.

The bowling picture does not look quite so bright. The loss of Walter (who has now qualified) has left a big gap in our opening attack, which will not be easy to fill. Fortunately, Knott, last year's captain—now a houseman—will still be available to open the bowling. The spinning department, apart from the obvious lack of a left-arm bowler, looks fairly complete. There is Davoodbhuoy, from Ceylon, who was so successful both for us and for United Hospitals last year, to bowl his quickish off-breaks, and to bowl leg-breaks, together with Crafts and Appleby, yet another recruit has been found in Butchey. It is hoped that we will be able to derive full advantage from this trio, for it is in leg-spin bowling that one of the main hopes for brightening the game of cricket rests, and that is one of the aims of Guy's this year—to play brighter cricket.

There are still one or two places to fill in the 1st XI, and we hope that we shall find some promising talent at the Freshers' trial nets to be held this week when the Pre-clinical term commences.

FOLKESTONE EASTER HOCKEY FESTIVAL

As usual, the first team took part in the famous Hockey Festival at Folkestone over the Easter week-end; and as has happened before, the weather was not too kind, but on, and especially off, the field the side's spirit was not to be dampened!

On the first day the Old Dovarians were beaten 2—1 in good conditions. Guy's played well, but were one down as a result of a defensive error, and not until late in the second half did Bennett score a fine goal that the side deserved. Shortly before the end, Bennett gave Guy's victory with a weak short corner shot that completely fooled the opposition, following a fine dummy executed by Appleby.

On the Saturday, Guy's came up against the Cossacks in heavy rain, and the pitch was converted rapidly into a bog. Again Guy's were soon one down, but in the second half a superb shot from Cripps levelled the scores in an undistinguished game.

The next day Guy's came up against Cliftonville, the best side in East Kent, and one wondered if the teams might have been badly matched. In fact, an excellent game of hockey resulted in front of a good crowd of spectators, and Guy's were unlucky to go down 0—2. It was soon apparent that a fine game was developing, and both sides produced some grand movements. Cliftonville scored from their well rehearsed method of taking short corners, but Guy's were unlucky when a good shot from a long corner by Bennett was disallowed. Hirst comfortably saved a penalty flick shortly after this The second half continued at a fast pace with further excellent hockey. Guy's defence completely confused the opposing forwards with clever use of the offside law, but unfortunately allowed a further goal in the only lapse of a solid display. Guy's still were not beaten, and a highlight is a very exciting game came when a superb shot by Bennett from a short corner was brilliantly saved by an opposing back. This was Guy's best game for a long time with the whole team playing well, and Bennett outstanding.

Against Trinity Hall, the team was contrastingly feeble, and a bad game in bad conditions ended 0—0, thanks to many good saves by Hirst playing his best game at the end of a fine career. A sad last game of the season rapidly to be forgotten.

Off the field the team was in fine fettle and did more than was asked of it. Lewis must take the prize for a number of fine performances which must augur well for his M.B. efforts—Harvey willing! It was good, too, to see the Sports Correspondent playing centre-forward for Jesus College, Cambridge: they lost all four games, this vindicating his absence from the hospital hockey sides.

Team: A. Hirst, D. Loader, K. Haynes, J. Crafts, P. Rushmer, R. Kendrick, R. Carruthers, S. Cripps, M. Appleby, P Bennett, P. Liddiard, M. Lewis.

The Spirochaetes visited Paignton for an equally enjoyable week-end in superior weather conditions. They also played some good hockey and came away with an impressive record of four wins and two losses, S. Din proving an excellent goal scorer.

Reports and Results

CROSS COUNTRY

It would be untrue to say that the Club has had a brilliant season, but some results are, nevertheless, encouraging. Twenty-six people have run with the Club this season, in the training afternoons over Parliament Hill Fields, the Guy's and U.H. home ground at Hadleywood, Barnet, and in the matches.

The matches consisted of five London Colleges League races, three relay races, five inter-college championship races, and eight private matches (of which three were cancelled).

In early October, a weak but spirited team was defeated at Hammersmith by Latymer School, but this was defeated in early February by Guy's men taking the first four places and eighth in a return match at Barnet.

On March 10th, after a close run, we were defeated by Imperial College's first team in the last mile-and-a-half over our home course. We did a very good run against St. Mary's College, Twickenham, "A" team, but could not claim a victory as we were not fielding a full team.

A new venture was a match against Clare College, Cambridge. This was a great success, meeting new faces from a Cambridge College, which we hope to continue, and to see their high standard of running.

In the London Colleges' League the team has retained its place in the first division. In the first race we were 11th, but in subsequent races finished 10th, which was the final position out of 13 teams. In the last race we finished 8th fielding our best possible team.

We entered the Parliament Hill Fields University College 6 x 1 miles relay, and the Borough Road, Osterly Park 4 x 3½ miles relay, but did not do so well this year in either as we did last year. In the Hyde Park Road relay we considerably improved our time and position with a field increased from 70 teams to 85 teams, finishing 51st.

In the Kent Hughes Inter-Hospitals' Cup we were a disappointing third, but Peter Witting and David Choat did their best runs, coming 3rd and 10th respectively. In the University Championships Guy's came 6th out of seventeen teams: a fine effort and considerable improvement.

E. J. BOWEN-JONES

CRICKET

GUY'S v. BECKENHAM

Played at H.O.P. on Saturday, 24th April
Beckenham won by five wickets.

Beckenham won the toss and put Guy's into bat in the first match of the season for both teams.

McGregor and Butchey gave Guy's a slow but sound start, the run rate being reduced by a slow outfield. McGregor was the first to go for 19, and Butchey soon followed. Of the remaining batsmen, Cutler played some attractive strokes, while Powell-Jackson and Crafts were the only others to reach double figures. Sowerby finished with 6—32, though he was helped by poor, indeterminate batting.

The Guy's attack was obviously short of practice, and only Butchey had the basic virtues of length and direction. He fully deserved his analysis of 3—26. They made the necessary runs quite comfortably, mainly due to an entertaining, if slightly lucky, 50 by their opening bat.

This was a match Guy's should have been quite capable of winning, and yet we contrived to lose by five wickets. All in all, a rather inauspicious start to the season.

Scores:

Guy's—100 (Cutler 21, Crafts 24 not out; Sowerby 6—32).

Beckenham—102—5 (Blackett 59; Butchey 3—26, Beacham 2—41).

GUY'S v. HORSHAM

At Horsham. Saturday, 24th April, 1965
Result: drawn

Against a ragged bowling attack on an easy-paced wicket, and aided by too many missed chances, Horsham amassed the formidable total of 180 for 3. A very fair declaration left Guy's equal time in which to score the runs. A good opening partnership by Butchey (76) and McGregor (24) and a fine aggressive innings by Cutler (34) put Guy's on the road to victory. However, 60 runs in the last half-an-hour in poor light was a little too much. Six batsmen unselfishly sacrificed their wickets in a brave attempt, but when Butchey was run out on the last ball of the innings we were still six short of victory.

J. K. CRAFTS

Horsham—180—3 (Rowlands 2—40).

Guy's—175—9 (Butchey 76, Cutler 34, McGregor 24, Powell-Jackson 24).

GOLF

DENTAL STAFF v. DENTAL STUDENTS

Played at Knowle Park G.C. 9th April, 1965
Result: match drawn 3½—3½

A good field of twenty-eight players turned out for this annual occasion. The superb surroundings of the club, set in the grounds of the famous house, encouraged adventurous golf. The light rough and trees without summer foliage, did much to tempt the visitor to go for the big shots. This led to a watery grave for some at the 13th in the ponds hidden behind the bunkers.

Mr. Stuart played a round he will remember a long time for his consistent power in all parts of his game Mr. Baker, a past member at Knowle, entertained with his tales of yesteryear. Clive Rowe had an eagle at the long 14th, and eagles promise to be rare this year under the new bogey rules.

Everybody agreed that a draw was a fair result for the day's play, and hoped that even more of our members would come down to enjoy the fixture next year.

PAUL NEWTON

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL & MEDICAL SCHOOL JUNIOR STAFF APPOINTMENTS, 1965-66

Applications are invited for the following appointments to the Junior Staff of Guy's Hospital, commencing on 1st October, 1965, for the session 1965-66. Forms of application are obtainable from the Superintendent, and should be lodged with him not later than **15th May, 1965:—**

Anaesthetics
- Senior Registrars 3
- Registrars 3
- Registrar 1*

Cardiology
- Senior Registrar 1
- Junior Registrar 1

Child Psychiatry
- Senior Registrars 2
- Registrar 1

Clinical Pathology
- Registrars 3
- Registrar (Haematology) 1

Dermatology
- Registrars 2

Diagnostic Radiology
- Senior Registrars 2
- Registrars 2

Ear, Nose and Throat Surgery
- Senior Registrar 1*
- Registrars 2

Endocrinology and Radioisotopes
- Registrar 1

G.U. Surgery
- Registrar 1

Medicine
- Registrars 3
- Junior Registrars 4

Neurology
- Senior Registrar 1
- Registrar 1

Obstetrics
- Registrar 1

Ophthalmology
- Senior Registrar (part-time) 1
- Registrars (part-time) 2
- Junior Registrar 1

Orthopaedics
- Senior Registrar 1*
- Registrar 1

Orthopaedic and Casualty
- Registrar 1

Paediatrics
- Senior Registrar 1
- Registrar 1*

Physical Medicine
- Registrar 1*

Psychological Medicine
- Registrars 3

Radiotherapy
- Senior Registrar 1
- Registrar 1

Surgery
- Senior Registrar 1*
- Registrars 3
- Junior Registrars 3

Thoracic Surgery
- Senior Registrars 2
- Registrar 1

V.D.
- Registrar (part-time) 1

*These appointments are under the Exchange scheme and will be made jointly with the South-East Metropolitan Regional Hospital Board and Guy's Hospital, as follows:

(a) **Senior Registrar in Ear, Nose and Throat Surgery.** The appointment will be for four years from 1st October, 1965, the first and fourth years to be spent at Guy's and the second and third years with the Lewisham Group.

(b) **Senior Registrar in General Surgery.** The appointment will be for four years from 1st October, 1965, one year to be spent with the Bermondsey and Southwark Group, and three years at Guy's.

(c) **Senior Registrar in Orthopaedic and Traumatic Surgery.** The appointment will be for three years from 1st October, 1965, the first and second years to be spent with the Medway and Gravesend Group and the third year at Guy's.

(d) **Anaesthetic Registrar (middle-grade) and Paediatric Registrar (middle-grade).** These appointments will be for two years from 1st October, 1965, the first year being spent with the Brighton and Lewes Group and the second year at Guy's.

(e) **Registrar in Physical Medicine (middle-grade).** The appointment will be for two years from 1st October 1965, with duties partly at Guy's and partly at New Cross Hospital on a day-to-day basis.

Applications are invited for the following appointments to the Junior Staff of the Medical School for the session 1965-66, commencing 1st October, 1965. Forms of application are obtainable from, and should be lodged with, the Dean, not later than **15th May, 1965.**

Chemical Pathology
Anderson Demonstrator 1

Clinical Pathology
Senior Lecturer 1

Medicine
Pre-Clinical Tutor 1
Lecturers 2
Junior Lecturer 1

Pharmacology
Junior Lecturer 1

Physiology
Junior Lecturers 4

Surgery
Lecturers 2

Applications are invited for the following Fellowships and Studentships. Applications should be made not later than **15th May, 1965,** on a form to be obtained from the Dean, Guy's Hospital Medical School, S.E.1.

The Adrian Stokes Memorial Fellowship

The Fellowship is open to qualified Medical Practitioners or Graduates in Science, in Pathology, or Bacteriology. Applicants must be anxious to carry out further study in Pathology or Bacteriology in any of their branches. The Fellow is required to carry out this study during a period of not less than six calendar months in his year of tenure, at a University, School, or Hospital or other Institution, subject to the approval of the School Council, except the School in which he has received his medical or scientific education. The Fellowship is of the value of approximately £460.

The Greville Studentship

The Greville Student, who is required to devote himself to original investigation in connection with the subject of Cancer, holds the appointment for a period of two years, renewable annually for a further period of three years, making five years in all. The Studentship is of the value of approximately £35 per annum.

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Registrar in the Ophthalmology Department,** with attendance on two sessions a week. Duties to commence as soon as possible, with appointment until 30th September, 1966. Forms of application are obtainable from the Superintendent, Guy's Hospital, S.E.1, and should be lodged with him not later than **12th May, 1965.**

THE ROYAL MARSDEN HOSPITAL, SURREY BRANCH, DOWNS ROAD, SUTTON, SURREY

Applications are invited for the post of **Resident House Officer (Radiotherapy) with Surgical Duties.** Senior House Officer Grade. This is a Post-graduate Teaching Hospital—a Radiotherapy Centre with high energy apparatus and 100 beds. The appointment will be for one year. Application forms can be obtained from the Administrator, to whom they should be returned by the **7th May, 1965.**

The Superintendent requires a SECRETARY, under 35 years, in personal office. Interesting and varied duties, including clerical and committee work. Salary £727 per annum rising by annual increments to £909 per annum. (Scale currently under review.) Post vacant immediately. Apply, naming two referees, to Mr. J. B. Blaikley, F.R.C.S., Superintendent.

PASS LISTS

ROYAL COLLEGE OF SURGEONS OF ENGLAND
Primary F.F.A.

Mavis A. Bonnard — J. C. Simpson — W. A. Wallbank — D. Farrar — B. R. T. Smith

NURSING NEWS

Entered

Sister P. Blackmore to Evelina Hospital.
Sister J. Foulkes to Theatre.
Sister G. Glover to Dorcas.
Staff Midwife F. Awde to Nuffield D.
Staff Nurse M. Wildish to Nuffield Theatre.
Staff Nurse J. Williams to Nuffield Theatre.

Left

Sister M. Boswell from Evelina Hospital.

CHANGE OF ADDRESS

HOSKINS.—To c/o B.P. Exploration Company (Libya) Limited, P.O. Box No. 263, Benghazi, Libya.

BIRTHS

GILL.—In Adelaide, S. Australia, on March 14th, 1965, to Kay (née Robinson, M.C.S.P.) and David Gill, M.B., B.S., a son, Andrew David, a brother for Anthony, Christopher, and Nicholas. Permanent address: Box 55, Tea Tree Gully, S. Australia.

JAMES.—On March 28th, 1965, to Sheila and Noel James, of 88, Waddington Avenue, Old Coulsdon, Surrey, a son, Paul Arther Howard.

DEATH

CLARKE.—On April 10th, 1965, suddenly, Godfrey Julian Clarke, L.R.C.P., M.R.C.S., late of the Sudan Medical Service and St. Helena, husband of Pamela, 8, Buttenshaw Close, Arborfield, Berks.

GUY'S HOSPITAL GAZETTE

FORTNIGHTLY ONE SHILLING VOLUME 79 NUMBER 2004

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EDITORS P. BOWDEN AND A. E. RAYNES

SPORTS CORRESPONDENT A. PROCTER

GUY'S HOSPITAL, LONDON

PASSIM

Machinery of Communication

A step to abort the chaos in scientific communication has been taken with the establishment, by the Government, of an Office of Scientific and Technical Information. Not long ago it was possible for the research worker to keep up with his subject by personal contact, just knowing the people working in his field, but with the rapid arrival of new techniques and progress in other areas he now has to search for his material in an information machine which has never been subject to any control. The extent of the chaos is exemplified in the recent estimates of the size of this machine which have varied between 30,000 and 80,000 regular journals.

Even within the relatively small confines of Guy's there is a tendency to reflect this situation. In an establishment concerned with the human problem approached from the bedside and the laboratory it is important to provide common meeting ground for these two sides, or else the value of having them in such close proximity is lost. The solution to this problem does not lie in the awaited arrival of some form of integrated teaching in the Medical School, for although it will help, this in itself cannot materialize without mutual understanding.

The expansion of Guy's will make informal personal contact increasingly difficult and our awareness of all that is going on in the hospital will be blunted unless this matter is carefully considered. Unlike the new Government Office, this will hardly involve the use of computer systems but some sort of hospital activity programming may well be of time-saving value. The frustrating experience of duplicating work is not unknown to us on a trivial level but if the machinery for communication becomes inadequate, then it is likely to grow to embarrassing proportions.

Children in the News

The intellectual press is providing a glut of articles on crime and childhood and it even periodically scrutinises pubescence with boring complacency. We are surrounded by papers on sociologic reform but they sink with their fellows to form a morass of well-intentioned irrelevance, and, as with medicine sometimes, one wonders who benefits from it all. The eightpenny Sunday papers print them as go-betweens amongst Nuryev articles, they are the cultured man's sensationalism, Borstal supplanting the sixpennies' Broadmoor. One cannot help feeling that the effects are similar but that the cause is less honourable, or at least, less honest.

They fail in that they do not achieve their aim in educating the public's ignorance. They have lost their Dickensian force because they are a scientific appraisal of an emotional problem. One sympathetic case history cuts more ice than a library of statistics.

We do not require a Reformation, to build new prisons of the old, but merely a means of making more people aware of the injustices of our time. To return to Dickens, he succeeded in his aim because he wrote specifically and well, so that those who read his work could not fail to realise the iniquitous exploitation of the child. The problems now are as different as they are debatable, they are not a matter of black-and-white but of degree. Familiarity does not breed action and the public will feel that much is being done. What is being achieved does not reach those who need its advice and lie at the root of the problem. To study the maladjustment of children we must first study the parents' problems or else the cart will overtake the horse. To diminish the incidence of behaviour disorder in the young we must educate the parents in the basic principles of fatherhood.

Sir Russell Brock has been made a Fellow of the Royal College of Physicians and Mr. W. F. Lund has been elected Ear, Nose and Throat Surgeon to the consultant staff of the Middlesex Hospital.

Regretfully we announce that Dr. B. H. Hicks has retired as Editor of the *Gazette*. Mr. Anthony Raynes becomes the new Assistant Editor.

The Dental Casualty Officers learned something of the lives of their Medical counterparts after the following notice appeared in the *Observer*:—

Teeth: Emergency Service for fillings and other distresses. Saturday mornings 9—12.30 *at Guy's Dental School, S.E.*1. *Saturday afternoon, from* 2.30 *and all day Sunday from* 9—*or earlier if you really can't stand it—at New Guy's House. Only real teeth, not plates.*

The response was terrific.

GUY'S DIARY

MAY.

EXHIBITION.		*Osteomyelitis.*
17th M.	1.00	Dr. TROUNCE. Clinical Lecture.. "*Iatrogenic Disease.*"
18th T.	1.00	Mr. BEARD. Clinical Lecture. "*Intestinal Obstruction.*"
19th W.	1.00	Radiotherapy Tumour Conference. Subject "*Carcinoma of the Kidney.*" Guest Speaker : Mr. KILPATRICK.
20th Th.	1.00	Dr. JOSEPH. Clinical Lecture. "*Measurement in Paediatrics.*"
21st F.	1.00	Dr. KAUNTZE. Clinical Lecture. "*Sabacute Bacterial Endocarditis.*"
22nd S.	10.00	Clinico-Pathological Meeting. Clinical Theatre.
24th M.	1.00	Sir RUSSELL BROCK. Clinical Lecture. "*The Present Position of Heart Surgery.*"
25th T.	1.00	Dr. MOYNAHAN. Clinical Lecture.
27th Th.	1.00	Dr. HARDWICK. Clinical Lecture.
27th Th.	5.00	Neurosurgical Round. Conducted by Mr. Schurr.
28th F.	1.00	Dr. G. WEBSTER, M.D., President of the American Society of Plastic Surgeons. "*Modern Trends in Plastic Surgery in the U.S.A.*"

HOSPITAL AND COMMUNITY CARE OF OLD PEOPLE PRESENT AND FUTURE TRENDS

JOHN C. BROCKLEHURST

CONSULTANT PHYSICIAN IN CHARGE OF GERIATRIC SERVICE
BROMLEY AND SIDCUP HOSPITAL GROUPS

According to the Registrar General's annual returns the proportion of the population of England and Wales of pensionable age shows the following trend :—

1911— 8%
1951—13.6%
1962—14.9%
1972—16.0% }
1982—16.4% } *Estimated figures.*
2002—14.3% }

This gradual increase in the proportion of elderly people in the population is due to the changing pattern of disease. The killing diseases of early and middle life—acute infections, pulmonary tuberculosis and to a lesser extent diseases such as diabetes mellitus and pernicious anaemia—no longer take their toll. People are now surviving to the years of retirement and the great scourges of to-day, and to-morrow, are the chronic disabling diseases: cerebro-vascular disease, coronary artery disease, chronic arthritis and neoplasia.

Family Care

Hospital and community care of old people begins to a large extent where family care leaves off. It is, therefore, pertinent to look at some of the facts about family care of old people in our present society, before considering hospital and community services. This is especially important since doctors are concerned mainly with the casualties of society and may easily develop an unbalanced view.

Fortunately, social scientists have in recent years paid a good deal of attention to the attitudes of society, particularly of the family, to old people. Professor Peter Townsend published *The Family Life of Old People* in 1957. This is a detailed survey of 203 old people in Bethnal Green—an East End working-class area, typical of a considerable proportion of our urban society. He found the following basic facts.

(*a*) 20 per cent of the old people had no surviving children. This one-fifth of the elderly population represents those particularly at risk.

Of the remaining four-fifths—

(*b*) Over 50 per cent had married or unmarried children living in the same dwelling; a further 25 per cent had such children living within 5 minutes' walk.

This article is based on a lecture originally given at Goldsmith College, in the series "Towards Better Medical Care."

(*c*) Almost 80 per cent saw *at least* one child daily. Only four per cent saw one or other of their children less than once a week.

It is thus apparent that old people with children maintain close ties with them. This is an extension of continuing close family contact throughout life—particularly between mother and daughter.

It might be thought that Bethnal Green represents only one side of the picture, and that the close family life which Townsend has shown there is by no means typical of other areas with different social structures. Again facts are available. Wilmott and Young published in 1960 the result of a survey in suburbia called *Family and Class in a London Suburb*. A section of their survey was concerned with old people and showed in fact that *more* old people shared a dwelling with married children in Woodford (where the survey was carried out) than in Bethnal Green. The difference was slight, but indicated that the extent of family care for its ageing members seen in Bethnal Green was not atypical.

One fact implicit in both of these surveys is that women in middle life, when their own children grow up and leave home, are increasingly having to look after their elderly relatives. This is a task which becomes more demanding as time passes and the old person grows older.

Hospital and Community Services at present

Before turning to the future, the present pattern of care of old people by society must be considered, and the difficulties which are at present apparent.

One point seven per cent of pensioners live in Old People's homes. These homes are of three kinds—State, voluntary, and private. Again we can turn to Townsend for information about them. He carried out a detailed survey of 171 such homes. This was published in 1962 in a book entitled *The Last Refuge*.

Townsend showed that the large majority of people in old people's homes were unmarried (single or widowed) or if married were childless. He showed the variability from one part of the country to another, in both the provision and the quality of old people's homes. He indicated that although Bevan in 1947 had been at pains to abolish the workhouse, in fact its atmosphere, regimentation and rules still persist in too many places. Admission to any institution (hospital or old people's home) means a loss of independence, and thus dependence on other people. The staff, and above all the matron, of an old people's home is the person in whose hands this dependence lies. The atmosphere of the home will thus mirror her attitude and personality.

Hospital Care

Hospital care of the old is largely, and increasingly, though by no means exclusively, the sphere of the medical speciality of geriatrics. There are now over 130 geriatric units in England and Wales, each providing a service for a geographical area, based on the hospital beds of the consultant geriatrician.

The geriatric service has a limited responsibility, which may be summarized as follows:—

(1) To accept patients from general practitioners for investigation, treatment and rehabilitation. To discharge as many of them as possible in an optimum physical and mental state back to their homes or to old people's homes, where they should continue to live as active a life as possible.

(2) To provide continuing care for a limited number of old people, on a Day Hospital basis, for one of three reasons.

(*a*) To continue their rehabilitation after they have become fit enough to live away from the hospital.

(*b*) To provide physical rehabilitation without in-patient admission.

(*c*) By continuing surveillance to prevent those at risk from relapsing into invalidism. (Many chronic disabling diseases cannot be treated once and for all, but require continuing physical treatment. The Day Hospital provides this in a therapeutic environment where the pace is suitable for old people.)

(3) To provide long-stay and terminal care for old people who are so disabled physically or mentally as to require continued nursing. This includes the provision of long-stay care for patients coming from other hospital departments.

(4) To provide some relief for relatives who are nursing disabled old people at home. This is best done in the summer (when there is less demand on hospital beds) by pre-arranged admission for 2 or 3 weeks, to allow the relatives to have a holiday.

(5) To undertake research into diseases and disabilities of old age; to teach the management of these conditions to medical students and nurses; to provide a lead in planning for care of the aged in the local community.

Care at Home

The brunt of day-to-day care of old people is borne by the general practitioner service, and forms an increasing proportion of the general practitioner's work.

The Health and Welfare Departments of local authorities are responsible for community social services—Home Helps, Home Nurses, Health Visitors, provision of nursing appliances, incontinent laundry and also the provision and management of old people's homes.

Voluntary bodies provide essential services such as Meals on Wheels and old people's clubs and visitors.

Present Difficulties

In the present situation, undoubtedly the worst served are the aged housebound, a group estimated at 10 per cent of the pensionable population (Sheldon 1948, Lewisham Survey 1964). Three hundred such old people were visited by Snellgrove (1963), a doctor in Luton, who described their plight in his book, *Elderly Housebound*. He found that physical disability was the main cause of their isolation. Thirty per cent of them lived alone. Loneliness was their great

scourge—and they represented about 700,000 old people in England and Wales. Relatives also, in certain circumstances, are subject to enormous difficulties. Sheldon (1948) in a survey in Wolverhampton found that 8 per cent of old people were causing great *physical* strain to younger people looking after them, generally a daughter. (It is worth remembering that the daughter of a 90-year-old woman may herself be 70.) Every geriatrician is constantly reminded of the *mental* anguish and marital disharmony which may result from the presence of a confused or merely cantankerous old person in the household.

As far as the hospital and community services are concerned the greatest present difficulty is an ever-increasing shortage of staff—nurses (trained and untrained), physiotherapists, occupational therapists, social workers, chiropodists, home helps, matrons of old people's homes.

A second difficulty is lack of adequate liaison between all agencies concerned in care of a particular old person—and especially between the three divisions of the health service.

The Future

I believe that future developments in this field will follow very closely on present lines as indicated in Fig. 1. It is surely reasonable to hope that the three divisions of the health service will become more closely joined together—in this sphere if in no other.

The person who should be in continuous control is the general practitioner. Every old person is on a general practitioner's list; it is he who should know them all, have identified the 20 per cent at risk, and be continually aware of their changing needs. To do this he requires a social worker as his assistant. This would seem to be the future trend, as described by Fry, Dillane and Connelly (1965) in their article, *The Evaluation of a Health Team.*

The geriatric day hospital is becoming firmly established. Complimentary to these are required Social Day Centres, run by local authorities or voluntary bodies. To these centres, isolated old people, not requiring medical facilities, may be brought by transport to spend one or more days in company with others each week.

Domiciliary physiotherapy—the early treatment of stroke at home—would seem a probable development. This should become a function of the geriatric physiotherapy department. It would be a stepping stone to the Day Hospital for continuing treatment, avoiding hospital admission, wherever possible.

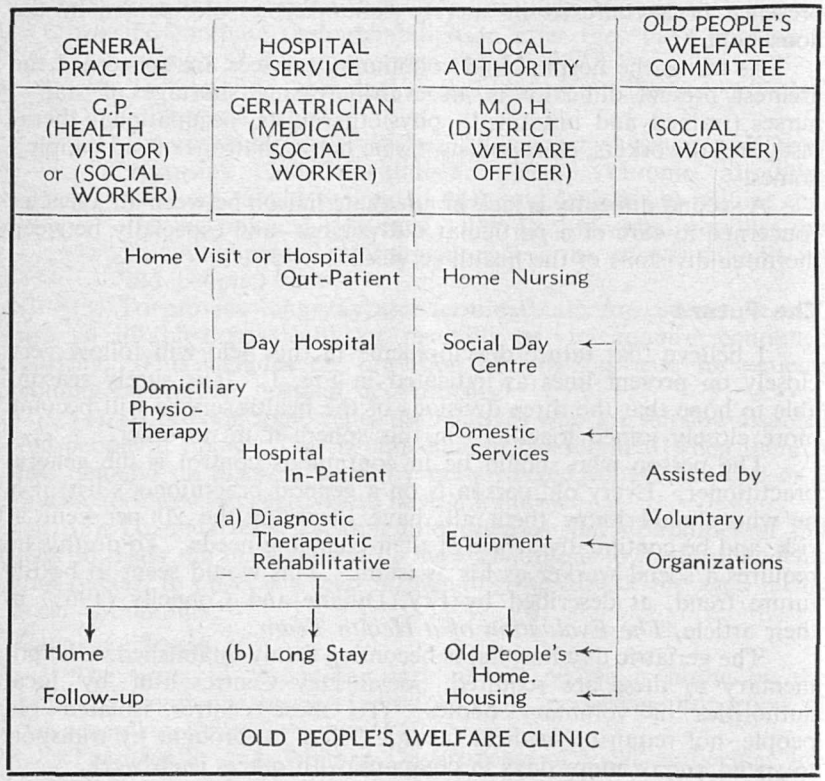
Old people's welfare clinics on the lines of child welfare clinics will emerge when medical manpower permits.

Finally, the whole question of retirement—pre-retirement training, graduated retirement and post retirement workshops provide a field in which enormous developments are essential.

Conclusion

This brief and sketchy survey suggests that future development of hospital and community services for old people will follow closely

the trends already apparent. In the setting up of group practice with an attached health visitor or other social worker, the general practitioner should assume a more positive and prominent function. He would know all the old people on his list—be aware of their changing needs—and provide hospital and community services as the need arises. He should become the focus of liaison between these different services in the context of individual patients.



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SHIP'S SURGEON TO S. AMERICA

"For the call of the running tide is a wild call,
A clear call, that may not be denied."

J. MICHAEL SIMPSON

I was sitting alone, engulfed by the cold, crude splendour of the Cornish coastline. I watched the waves being urged, as by a mighty hand, for ever onwards to end their short, dramatic lives by crashing their hearts out on the rocks below, or easily running past to point their gurgling, searching fingers up the crevices as the shore dictated. The land remained as firm as the examiners had been at Queen's Square and the personification was apt. The multilayered rock painted immediately with tar and an overcoat of minute shells, only occasionally would selectively enfold a portion of the sea, shutting it off for ever from its striving fellows into dark, green, mysterious pools, each to cultivate a little world of its own. In my sorrow my sole fellow observers were the gulls, arrogant, selfish, for ever listening and watching the coast at work, sweltering at times in its stinking misery. It was enough. I stood up, kicked an empty can into the ocean and decided to run away to sea.

My application was successful, and when I found my new home in London's Pool two weeks later, she was having her nappy changed. She lay somewhat east of the Limehouse "Old Friends" as the Chinese crow flies, and sat snugly at ease whilst dockland moved around her and paid attention to her comforts.

The new surgeon's arrival was unromantic, and met unnervingly with an air of sympathy. I was shown my cabin and then deposited in the surgery with several large bunches of keys. I gazed around. A large, dark bottle glared instructively "The Black Purge" at me, the theatre gown tin marked hopefully "sterile" was rusty, and the washing basin produced only dust when the foot pedal was pressed. I sat down at the small desk and gloomily contemplated major surgery. I had visions of being assisted by a bawling captain, with a drunken first mate as runner, whilst the stewardesses sang hymns in the background and the whole ship's company prayed.

I sighed, picked up all the instruments, put them in the steriliser, and pushed the switch on. There was a blinding flash from the depths of the oven and the fuse box turned black, and at this moment the butcher chose to neatly amputate the top of his finger. But, soon we were away, moving backwards to impressive blasts from the funnel, pushed and pulled onto the beaten track by the fiery little tugs which were to provide such a fascination for me in whichever port we visited. My vague airs of depression and foreboding were blown away by fresh sea breezes, a reduction in bar prices, and a glamorous uniform, and the world grew smaller, my relative importance grew larger, and the ladies grew sweeter. I began to enjoy myself.

Medicine was interesting.

An excited little Spaniard, who spoke English only with his hands, called to see me, and we decided mutually that he wanted tincture of iodine. It occurred to me after he had gone that he might well drink it, but he disappeared at warm, friendly, gentle Lisbon. The capital of Portugal is an important gateway to the sea-going Western world and therefore bears a certain dignity and sanity towards passing customs. It is built, like Rome, on Seven Hills, which are in fact volcanic. In 1775 she split her seams in an earthquake, geographically changing the housing plan, and resulting in the creation of the new and old parts of Lisbon, which are effectively contrasted in character. Her lobsters are famous and, for me, so is one very large and fat policeman who sat down on a plate of equally famous sardines, and just smiled.

Two days later we hit Las Palmas, very gently, so as not to awaken her, and then bartered furiously with quayside Spaniards, bearing away with us anything from cameras to canaries. And so we set off to roll down to Rio with plenty of flying fish and sunshine. My cases grew and included carcinoma of lung with a short history, threatened abortion, pneumonia of all things, asthma, numerous cuts, boils, sore throats, the Bos'n's feet, "that" disease, neuroses, and finally 580 miles from the nearest land a medical S.O.S. from a 10,000-ton Royal Mail cargo boat. The deeply disturbing telegram stated "Impacted dentures in lower gullet for 18 hours in crew member 35 years. Advised immediate operation under general anaesthetic imperative."

Immediate panic, "Nelson's" amputation saw in my cabinet, and the captain's slow, "Well, doctor?" clashed in my mind, but they were only forty miles away and we had to answer the call. Three hours later the two ships met in darkness and a small gale, with 500 yards of shark-infested water to be navigated. I thought about the situation very seriously and decided that in spite of a life jacket my hours were numbered and that the bar was open. A gentle beverage, a chat about old times, and I felt strong enough to play table-tennis rather than dissolve in alcohol or tears, causing an old lady to gravely whisper, "I see, Doctor, Drake before the Armada."

However, the lifeboat coming to get me was swamped in launching and the doctor's life was saved. As good fortune has it, so was the unfortunate patient's.

Rio de Janeiro, or the River of January, was discovered by the Portuguese. It presents for immediate inspection, after an introductory roll, one Sugar-loaf mountain, one Copacabana beach, and a statue of Christ standing with outstretched arms amidst the characteristically undulating mountains, watching over the busy bay below. And it is all very beautiful. At night-time the twinkling lights give the panorama an air of warm sophistication which is almost unreal in its magnificance. We passed onto Santos, which I anticipated, quite correctly, would be a mistake. A delightful shanty-town run-in preceded a trip ashore to view the sights, and the ladies therein caused half the ship's

company, including the doctor, to be late. Montevideo is getting lazy in its habits and the police and customs officials worse, but Buenos Aires proved to be my complete downfall. We stayed a week and I grew more and more adventurous, but when the Chief Engineer informed me one morning of my engagement the previous evening to one Senorita Favorita of the Hong Kong Bar, I knew my money would go in future on Argentine steaks and shoe-shines.

So we journeyed back the way we had come, greeting recent friends like old ones, and the surgeon treating the consequences. The Bay of Biscay was kind to us, and the rather delicate deck-chair, crushed beyond recognition by a rather plump lady, was purely incidental. And then the white cliffs of Dover, nostalgically more appealing than ever before, and a call to see an elderly fibrillating gentleman with a cold, white and pulseless left leg allowed the Master a fast, dramatically clear run up the Thames. The gleaming ambulance with flashing light and clanging bell caused even Charles, the Welsh barber, a cynical man by nature, to sigh and wish he'd "been a doctor, mun."

We were back to a bigger, more serious, bitter world. I was unemployed but with a store of valuable memories and new friends. I was home and, some might have added, dry.

Residents' May Ball

Mrs. Beard has kindly accepted the invitation of the President of the Residents to act as hostess this year. She and the President will welcome guests at 8 p.m.

There are a few remaining tickets for the Ball, which will be held at "The Pigalle", Piccadilly, on Friday, 21st May, still available, and these may be obtained from the President or myself.

Will any guests who wish to be seated at tables with particular friends, please inform me as soon as possible if they have not already done so.

D. K. C. Cooper,
Chairman, Ball Committee.

Guy's Hospital Music Club
Brahm's Requiem

It is planned to perform Brahm's Requiem in St. Paul's Cathedral on Tuesday, 25th May, at 7.00. The choirs of the Music Club will join the Newgate Singers and will be conducted by Cecil Cochrane. The proceeds will be given to U.N.I.C.E.F. Further details will be announced later.

M. J. Lindop, *Secretary.*

A SPECIAL APPOINTMENT

by A. Kumar

En-route to India

Your first glimpse of India is Bombay Airport en route from London to Madras. It is, indeed, a disappointment as this airport could have been any that you have already passed, Frankfurt or Cairo. Within forty-five minutes Bombay was behind me as the plane ascended for its next air-stop. Between Bombay and Madras, flying at 30,000 feet gives you a panoramic view of India, a mosaic of gigantic size, a geographical model complete in all possible details. The silent land gives no clue that it harbours over 500 million people. In less than fifteen hours I had left England to arrive in India, where I was to spend the next three months as a special appointment at Madurai Medical College, Madras University.

As a native of Malaysia, this was going to be my first experience of India. The only link I have with this country is in being able to converse in two south Indian languages, Tamil and Malayalam. These were the regional languages of Madras State and Kevala State, respectively. It was amazing to see that the small Madras Airport was thronged with people. I learnt that this was due to each passenger having about ten relatives and friends to greet him on his arrival or departure. Garlanding with roses was another feature not often seen at London Airport.

My train ticket to Madurai allowed me two days' residence in Madras City. The poor as well as the rich can be seen to intermingle in the bustle of the city, the tropical sun, dust and noise complete the scenery. Except for the luxurious goods, cars, radios and refrigerators, the cost of living is cheap. A good meal of rice and six curries costs about a shilling and you can get as much as you want.

The Madras Railway Station is like Victoria Terminus, London, on a Bank Holiday, but perpetually so. All first class tickets have to be booked three weeks in advance and I was fortunate in having a sleeping birth accommodation to Madurai on the Madras-Trivandrum Express. I realised, after boarding the train, that pillows and sheets for the berth have to be provided by passengers. The 300-mile journey took almost as long as the flight from London to Madras on the narrow gauge rail lines. I was initiated to India.

Madurai Hospital

The Government hospital is the oldest establishment in Madurai District. It was opened in 1842 in the old Guard Room of the remains of Madurai Fort. The hospital was taken over in 1918 by the Government and extensions and improvements to the old settings were needed to meet with the increasing popularity of the hospital. The largest

addition was in 1940. It was then re-named Erskine Hospital, Madurai, after Lord Erskine who was a former Governor of Madras State. In 1955, Erskine Hospital was converted into a teaching institution and acquired a bed strength of 1,100. Special departments were set up: Tuberculosis, Blood Bank, Family Planning, Dental, Leprosy, V.D., Eyes, E.N.T., Paediatrics, Orthopaedic, Biochemistry, Pathology and Psychiatry. In 1964, Neurosurgery, Paediatric Surgery, Plastic and Thoracic Surgical Departments started functioning. A Tuberculosis Sanatorium and Infections Hospital just outside Madurai are attached to the Erskine Hospital. Time only permitted me to attend the surgical, medical, obstetrics and gynaecology departments in rotation for two weeks each.

General Surgery

The Professor of Surgery, A. A. Asirvatham, M.S., F.R.C.S., has five surgical units besides his own. Each unit has two Registrars and four Housemen, excluding post-graduate students. They operate three days a week, starting at 9 a.m. About fifteen cases are dealt with, of which two or three are major surgery, gastro-jejunostomy, thyroidectomy or laprotomy. The rest of the cases tend to be hernias, piles or urethal strictures requiring dilatations. Spinal anaesthesia is given whenever possible, mainly due to shortage of equipment and manpower. Apart from examinations of urine, haemoglobin level and occasionally blood urea, investigations are kept to the minimum. Ward rounds and out-patients take place daily, including Sundays.

Ulcer patients are a common problem in South India. They usually attend hospital with the severe symptoms of an advanced ulcer. Perforation is not encountered frequently and pyloric obstruction is the commonest complication. It was felt that healing with fibrosis was more intense and rapid than in Western countries. The result was that a medically treated ulcer patient may return in three or four weeks with severe vomiting and inability to retain food. A large proportion of healed incisional scars result in keloid formations—a problem for plastic units in India. Surgical treatment for peptic ulcers is usually gastro-jejunostomy with or without vagotomy. Gastrectomy is not popular with many patients and surgeons as it tends to reduce the quantity of rice that the patient can consume and results in a grossly demoralised individual. No South Indian feels adequate gastric-wise unless he had his daily quota of rice, about ten cupfuls at a sitting.

A tetanus ward has been instituted to meet with the daily admissions of one or two cases; they are of all ages. Trauma of some two weeks' duration is usually evident, often in the form of minor and insignificant looking cuts, these have generally not been treated. Antibiotics and sedatives have saved about 50 per cent of admissions. The high mortality is due to very late admission when the spasms have become generalised. "Madura Foot" is encountered frequently in the hospital. This is a fungus infection, localised to the foot. The classical lesion results in spore-filled sinuses extending into the tarsus of the

foot. The Professor of Surgery is at present conducting research into this condition which is named after the town.

Obstetrics and Gynaecology

There are over three hundred beds for this department under Professor Bhasker Rao, M.D., M.S., in a separate block within the hospital compound. It conducts about 4,000 deliveries yearly, a figure which is increasing annually; the labour-room has facilities for about ten deliveries at any time. One Houseman said, "Drop in any time, day or night, and I can promise you a delivery." Most of the women have had between six and twenty deliveries. Most of these mothers have only about half the children surviving over the age of ten. Though "birth-addicts" through circumstances beyond their control, these multi-gravida have great affection and love for every new child born. The high infant mortality may predispose to the population breeding. There is a basic insecurity among the poorer class, probably that a child has a great risk of death before adulthood. To compensate this, possibly, large families are a common feature of Indian life. This is only my speculation of a factor in the high birth rate of the country. Family planning schemes have begun to infiltrate the country and consent for sterilisation is obtained quite easily. Ruptured uterus cases are encountered as one of the obstetric emergencies much more frequently than in England; these cases usually come from distant villages and the long journey in horse-drawn carts enhances the shock as well as predisposing to high mortality rate. Gynaecological problems commonly met are puerperal infections, prolapse and neoplasms in that order.

Medicine

As in surgery, there are six units headed by Professor Prabbu, M.D. It is in this field, especially, that diagnosis has to be made by physical signs. The facility for elaborate chemical investigations are limited. Seldom are blood cultures or stool cultures taken or results awaited prior to treatment. The ill-nourished health of most patients does not justify any delay. Cholera patients are sufficiently dehydrated on admission to receive up to about eight pints of saline/glucose intravenously within an hour!

The miracle of medicine in India is the antibiotic. It is a true life-saver and has contributed to the success of hospitals and degradation of Ayurvedic treatment. Failure to thrive is a recurrent symptom of patients. Tuberculosis is responsible in most cases and has to be eliminated before any other diagnosis is made. Anaemia has its share of patients and haemaglobin of 40 per cent is a routine finding in the out-patients. Many admitted to the wards, some with such figures as 10 per cent. Insufficient dietary requirements leads to the appearance of classical deficiency syndromes. Worms of all description inhabit over 80 per cent of the population.

Patients

The Government Hospital gives free treatment and attracts mainly the poor-class patients (a few paying private wards exist). Most of

them travel by horse carriages to the hospital. Those who cannot afford daily transport for out-patient treatment are admitted whenever possible. I enquired about the bed-strength of the hospital wards. The Registrar was quick on the mark, "bed strength is 50; floor or mat strength is 150; after that the only strength left in emergency is under the bed". The overcrowding of the wards results from a humane outlook that no patient in need be refused admission.

Patients are bad witnesses and difficulty is created in trying to interpret Tamil slangs and descriptions into English medical terms. (All proceedings in the hospital are conducted in English.) They are simple, naïve people who put all their faith in the medical profession. A genuine "Your Life in Their Hands". As a young and upcoming doctor said, "It is the implicit trust they have in me which gives me the strength and determination to help them, in spite of overwork and under pay". Nowhere have I seen man or Earth being raised to the esteem of Saints through the medical profession as in India. I cannot see this being continued, however, as the modern materialistic life of India is rapidly replacing faith by rupees.

Nursing Staff and Medical Staff

Each ward, with about 200 patients, will only be manned by about four nurses. Male nurses, or Masters, are used in medical and surgical wards to reduce the shortage of staff and to maintain law and order. Each patient has usually at least one relative residing with him and this helps to add to the chaos in the wards. The nurses have to keep a very sharp eye indeed to catch the relatives in possession of contraband food for diet restricted patients. All unit chiefs are either qualified as Masters of Surgery or M.D. of Indian Universities. In addition, most of the senior staff have gained experience in the U.K. or U.S.A. Thus, Guy's Hospital and its contributions to the medical world were familiar to them. Clinical meetings are held every fortnight and there is no lack of interesting cases which are presented by each unit in turn under the Chairmanship of the Dean, Mr. C. K. P. Menon, M.S., F.R.C.S.

Pay scales seem poor for the work done by the medical profession. Post-graduate full-time students have to give two or three years' unpaid service to the hospital. This is a pre-requisite for the M.S. or M.D. examination. During this period they have no financial income.

Beyond the Hospital Wall

The hospital lies south of a wide river, like the Thames, with a new bridge connecting it with the centre of the town. Madurai is a large town with narrow, crowded streets, famous in South India for its magnificent temple. During festival times the town is a sea of human flesh. The streets of Madurai are well noted for their donkeys, which are let loose by their owners, the Dhobies. The donkeys are transporters of laundry in the mornings and "official traffic-speed regulators". Having stationed themselves in the middle of the road, they make an ass of themselves by being totally indifferent to the motorists' frantic hooting!

The Hindu religion is deep-rooted in the minds of the people. A boy of 12 years of age, admitted with intersusception, yelled when the colic occurred: "God, what evil have I committed to be punished in this manner." The feud of the good and evil is a constant theme of nearly all Tamil films and theatre shows. This duel is portrayed with no sophistication. These, while appealing to the masses, fall short of the requirements of the educated and intelligent class.

Christianity and Islamic faith flourish in India as a minority group. The missionary activities still continue as in the Christian Mission Hospital, Madurai. With independence of India and gradual withdrawal of foreign aid, to the Mission Hospital, there has been a great setback to mission activities. The Mission Hospital of Madurai is a clean, neat and efficient place. It has a very high standard under the guidance of experienced clinicians who are paid low salaries. However, the hospital has to charge exorbitant prices to the patients for its daily functioning. The problem of financing itself has led the Mission Hospital in Madurai, anyway, to be of service mainly to a wealthy community.

An Impression of it all

What is the overall medical picture a stranger would leave India with? It is a gregarious land with a vast clinical wealth, untapped as yet. The progress on the medical scene is a mere trickle to what it would be with more resources. The conditions of the medical profession encourage few to study "medicine for medicine's sake". The material world's influence on India has clawed its way into the medical mind, resulting in many a good man degenerating himself.

Probably the root of all evil lies not wholly with the medical profession, but the low standards of living of the population. Public health and mass education is the only answer. Thus diseases of unhygienic living can be eliminated. But India has a long way to go to overcoming these problems. India is now gripping with situations encountered in Western countries some fifty years ago. It is an education by itself to see how this vast continent of India is tackling the problem—by well established ways, by new ways and often by a combination of old and new techniques and principles.

Acknowledgements :

I wish to extend my sincere thanks to:—
Dr. (Miss) Thelma Rasalam, D.G.O., M.R.C.O.G. (Mission Hospital, Madurai).
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Dr. (Mrs.) Remadevi Menon, B.A., M.R.C.P. (Rayonpuram).
Dr. C. K. P. Menon, M.S., F.R.C.S. (Dean of Madurai College).
Staff of Madurai College
for making my trip to India a most successful and enjoyable one.

CORRESPONDENCE

The Status Seekers

SIR,—Having read a few hundred Passims, I cannot recall a more ridiculous piece of drivel than that which appears under the above heading on May 1st.

To be satisfied with conditions in General Practice under the National Health Service is presented, not only as a virtue, but also as a manifestation of some sort of social superiority. In the event, anyone who has been in General Practice for a few years and remains satisfied with conditions as they are to-day, must surely have lost all his critical faculties and have resigned himself either to an inevitable decline to the " Please see and treat " fraternity or an early death from a coronary.

Whilst it may possibly be argued that a Public School education makes one more able to accept adversity and therefore do a reasonable job of work under discouraging conditions, Passim would have us believe that there is some advantage to General Practitioners and their patients in deliberately maintaining poor conditions of practice which are inherent in the operation of the National Health Service. Present medical students, be they from Grammar or Public Schools, should they think of entering General Practice, would do well to weigh up carefully where their priorities lie. If their interest is in clinical medicine or status or remuneration, they are likely to be disillusioned if not discouraged. If, however, they have an optimism for the future changes which over 75% of the present General Practitioners are determined to see fulfilled, they will at least be approaching their future on a realistic if not, in the view of the writer of Passim, a socially acceptable basis.

Yours, etc.,

B. A. TUDGAY.

Belmont Surgery,
Wadhurst,
Sussex.

Death's Omission

SIR,—I was very interested to read Dr. Keith Simpson's letter in the *Gazette* of May 1st. I agree entirely with what he says about the disposal of the dead. He has also given me a ray of hope concerning my ultimate future, as he says in his letter . . . . " death, sometimes violent, sometimes merely mysterious, comes to *most* of us in the end . . . "

I would dearly like to know how I can become one of the select few immortals!

Yours, etc.,

E. ROBINSON.

14, Bronwydd Avenue,
Penylan,
Cardiff.

Family Planning and the Unmarried

SIR,—I would like to take issue with your views on this subject in the recent Passim, particularly in relation to the help the doctor gives to the unmarried. I believe it is time that the doctor played a more active role in this matter, not merely supplying the contraceptive needs of unmarried patients. Who will uphold the moral principles, which have long been the basis of our family life, and of our civilisation, if the medical profession remain neutral?

This is not to advocate a moral dictatorship to their patients, but surely no one is better able to advise on the short and the long term ill effects of promiscuity. Evidence in Western countries shows that contraceptives are not the answer to illegitimacy. This is a parallel situation to smoking and lung cancer, which medical men have now tackled squarely.

In Norwich, on whose Health Committee I sit, the illegitimacy rate last year was 8.9%, and this is rising steadily, as does the breakdown of marriages and homes everywhere. Surely the medical profession, and Guy's men in particular, should accept responsibility in this matter. They alone could best turn the tide of public opinion. While dealing with compassion with the individual, they could call a halt to this destructive influence in our home and national life.

Yours, etc.,

L. G. RICHARDS.

St. Mary's Croft,
Chapel Field North,
Norwich, Norfolk.

Sports Day

SIR,—The Annual Sports Day, which this year is to be held on Saturday, May 29th, at Honor Oak Park, promises to be a great occasion. The Athletic Club have recently won the University of London Championships, and this augurs well for the serious athletic events in which we can expect some good performances. Those that can combine good athletic achievement with fast beer drinking will be invited to enter for the beer race; there will be a separate 100 yards event for residents; and those couples that can manage on three legs will have their own race. In addition to the athletics there will be numerous side-shows, all designed to cajole you into parting with the odd sixpence or so to help pay for the prizes and hire of equipment. Mrs. Slessinger has very kindly agreed to present the prizes at about 4.30 p.m.

Sports Day will be concluded with a barbecue-dance in the evening. Music will be provided by the " Sassenachs", and the licence has been extended for the occasion.

For further details, the posters liberally distributed around the hospital should be consulted.

Yours, etc.,

J. M. G. HUNT.

Guy's Hospital,
London Bridge, S.E.1.

British Dental Association Annual Conference in Belfast

SIR,—I have been asked to act as convener for the Guy's Hospital Dental School Alumni Luncheon for Dental Surgeons attending the Annual Conference in Belfast. It will be held at the Malone Golf Club on Monday, 21st June, 1965, and I would be very grateful if any members who would like to attend would be kind enough to contact me as soon as possible. Transport will be arranged for those who require it and the club has been kind enough to grant the free use of the facilities of the club-house and golf course to those attending the Conference.

Yours, etc.,

W. C. KENDRICK.

Eia House,
224, Antrim Road,
Belfast 15.

REVIEWS

OUTLINE OF UROLOGY

by Charles Creevy. 1st Edition. Pp. 356. *Price* 62*s*.

It is difficult for the student who is interested in urology to find a textbook that is entirely satisfactory. Consequently he may limit himself to the urology sections of the large, comprehensive textbooks of surgery. This is a mistake, as urology is a rapidly expanding branch of surgery and the larger general textbooks are not always entirely up to date. Mr. Creevy, an experienced and eminent urologist with many years of both undergraduate and postgraduate teaching to his credit, has produced an entirely new textbook which partly serves the student's problem.

The book starts with a clear and concise chapter on the anatomy and physiology of the urogenital system. There is a useful section on the instruments used in urology, including a description of the various catheters and the technique of urethral catheterisation, although the American nomenclature is at times confusing. In the remainder of the book the clinical material is clearly presented in a readable and easily absorbable form, and the text is frequently illustrated with diagrams and many excellent X-rays, some of which, however, lack sufficient explanation. The section on acute renal failure is a valuable addition. Throughout there are many helpful references, and the Bibliography listed at the end of the book is extensive.

However, as is frequently the case in reference books of this size, in order to be complete, yet brief, the distinction between the common and the rare is under-emphasised, to the detriment of the former. Less than two pages on the treatment of bladder neoplasm is insufficient. Although the author claims that his book is primarily written for medical students, its content is more comprehensive than the most exacting of examiners would require. For post-graduate study the book is excellent.

J. R. W. GUMPERT.

LIVING WITH CEREBRAL PALSY.

by T. INGRAM, S. RAMESON, J. ERRINGTON, and R. MITCHELL. W. Heinemann Ltd., 1964. Pp. 106. *Price* 20*s*.

This is solely a book for those who are interested or specialise in paediatrics and the problems of cerebral palsy. It has an interesting approach to the problem combined with information gleaned from a Scottish survey. It shows, statistically, how a handicapped section of the community realises the potential that it has, and compares the achievements of those who live in a big city with the handicapped in smaller towns.

Because of the low prevalence of cerebral palsy there are often not enough patients in an area to merit specific attention to their needs, the ways in which palsied men and women can be usefully employed are discussed. The most important point that emerges is that the cerebral palsy child who is fortunate enough to have a stable home, without over-protection, realises most in his achievements.

It can only be recommended to those to whom the problem is of special interest, to those people it is a particularly worthwhole book.

ANN WEBB

THE CARE OF THE INJURED—Published by Livingstone, London, 1964. In the review of this book, which appeared in the issue of 6th March, the author's name appeared erroneously as "Paring"; the name should have read *P. A. Ring*.

PRINCIPLES AND PRACTICE OF PLASTIC SURGERY.

by A. J. Barsky, S. Kahm, and B. E. Simon. 2nd Edn. McGraw Hill, New York. Pp. 783. Illust., 2,200. *Price* $35.00.

Dr. Barsky is not only one of the senior and most authoritative plastic surgeons in the United States, but, indeed, in the whole world of plastic surgery. The book and its authors deal with the practical aspects of plastic surgery. The whole field is covered; naturally some aspects more closely than others. Plastic surgery started some three thousand years ago in India in the Surgery of reconstruction of the nose, and it is natural, therefore, to read with interest of this work in this book as to see in an entirely practical manual so full an account of the plastic surgery of the nose. It is a section which is recommended without hesitation, covering as it does so many practical years in the multitude of different repairs of the nose, which may be indicated. The section on the breasts is full and characteristically of a practical nature. Your reviewer regrets the incorporation of a diagram of Passot's method of breast reduction. One patient in London, who had this type of operation, fifteen years ago, for the reduction of very large breasts by a most prominent surgeon, described her feelings about the result as "he gave me these tired sacks"; the operation should surely be buried in history. Nor does Dr. Barsky mention the Strombeck operation by which in your reviewer's experience there is the maximum safety to the viability and the sensibility of the nipples and with best breast shape. Equally, one regrets the illustration of the use of etheron prostheses for the flat chest. Cronin's silastic prostheses give a more normal feeling breast, although this, too, has difficulties of its own. The question of selection of patients for any type of augmentation mammaplasty needs very careful assessment. It is pleasing to see Dr. Jerome Webster's operation for gynaecomastia described in detail. Dr. Barsky, whose influence on the treatment of burns all over the world has been a marked one for the last thirty years, has a characteristically full and comprehensive treatment of this subject. In it he follows Gillies' example in the classical text book of Gillies and Millard in giving in some detail the early treatment of a burnt patient, including charts for the estimation of the fluid administration. The accounts in both books are excellent, but your reviewer doubts if the place for them is a book on the art of plastic surgery.

ESSENTIALS OF FLUID BALANCE.

D. A. K. Black. Blackwell Scientific Publications. Third edition. *Price* 25*s*.

Many students confess to a feeling of despair when trying to tackle the vexed problem of fluid balance. This is most probably due to the variance that exists between the approach of the chemist and that of the clinician. Caught between these two camps the student remembers a little bit of his preclinical teaching, confuses it with what he is taught on the wards, and ends up by feeling that fluids and fluid-balance will always be terra incognita to him.

If this mythical student has not stopped reading yet I would strongly urge him to read this book. Its overwhelming success is due to an essentially clinical, practical approach. This new edition introduces the concept of the hydrion, far superior to the old acid-base balance, which the chemists have long since stopped talking about anyway. It is extremely well set out in the tradition of Blackwell publications and very readable. Each topic is dealt with fully, separate chapters being devoted to general properties of body fluids, water, sodium, potassium, hydrion and the final chapter on an approach to treatment is quite admirable. Finally the list of references is both exhaustive and up to date.

One or two minor quibbles are the references to sodium as base, relic of bygone days and probably to disappear in future editions; the phrase kaliopenic arrhythmia which appears on page 76 is quite horrible; but this is a personal aversion.

Altogether, this is an excellent book.

RAYMOND PIETRONI.

JAMES MARSH BROWN, F.R.C.S.(Eng.)

The sudden news of James Brown's tragic death will have deeply grieved his many friends. I have enjoyed his friendship since going to Guy's in 1932. Indeed, James had a genius for friendship which he extended to many circles. He had an educated and articulate mind, and enjoyed a trenchant Johnsonian-like turn of speech. Exams. were never any difficulty to him. He got the primary and the final fellowship first go, being one of that group of Guy's men in the 30's who passed the final shortly after qualifying.

We joined the R.A.M.C. on the same day at virtually the same moment, arriving at Millbank by simultaneous taxis travelling from opposite directions. At the end of a week we repaired to the Registrar's Office for posting. We had been informed by the Clerk that for the thirteen of us there were twelve vacancies. Eleven of these were to Ack-Ack regiments around the coast of England—a very dim prospect—and one was to the Blues at Windsor. There were only two of us with the Fellowship and I had hoped for a posting. In the event I was left and James went to Windsor, where he stayed for the rest of the war. Indeed, his strongest wish was, by 1944, to go with the Guards Armoured Division to Normandy. At this time the War Office had a line of suitable young men to succeed him at Windsor with the Blues, but none, apparently, turned out to be entirely suitable, and James was recalled at the Monarch's express wish. If one is not, when of military age, to have service outside the U.K. during a war it must be a very real and, indeed, rare consolation to know that this was at the express wish of the Monarch.

He went to the Blues at Windsor as a Captain in the R.A.M.C. Shortly afterwards he was offered a commission in the Regiment. On the recommendation of senior officers he became Surgeon Captain Brown, remaining in the Regiment until well after the end of the war and subsequently on its reserve. He was a member of the Officers' Mess, Combermere, until he died. Living in Windsor, he used the Mess as his Club almost daily. After the war he continued to enjoy a wide circle of friends throughout Windsor, at the Castle, and amongst the staff at Eton. Throughout the years he did much of the surgery for the school in the Eton sanatorium and at King Edward VII's Hospital. He was, in effect, surgical advisor to the Household at the Castle, and medical officer to the Royal Ascot Meeting and the Windsor Race Course, where one could always hope to see him, or in London, at Bucks'.

He was a most kind and consistently polite man. As a surgeon he ranked very high in patient care, and many of his friends in Windsor would trust themselves to surgery only in his hands. He was a good friend to all at Guy's and was supported in this friendship by his wife, Kaye, a Guy's Sister. They never failed to extend their kindness and interest to Guy's people in any way they could. He will be very much missed in widely different circles at Windsor, Guy's, and elsewhere, and will always be remembered with affection and respect.

P.W.C.

Guild of Ex-Patients and Friends

The 17th General Meeting of Guy's Guild of Ex-Patients and Friends, held in the Medical School on Wednesday, April 28th, 1965, at 6 p.m. Miss MacManus opened the meeting by welcoming the ex-patients and friends. She told the meeting that the late Miss Beardoe-Grundy, who died February, 1964, aged 92 years, had left the interest of £1,000 to the Guild—she knew Miss Beardoe-Grundy first as a Nurse, then as Sister of Job and Naaman Wards—and (1905) was appointed the first Almoner to Guy's.

Mr. Carlisle, the Hon. Treasurer, in presenting the accounts, noted with pleasure the increased income, and explained they had this year purchased a new X-ray (the Panagraph) for the Dental Department, and a projector for cineangiocardiography to the Cardiac Department.

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SPORT

CRICKET

Won 1, Drawn 2, Lost 3 is not a very distinguished record after the first two week-ends. There are three chief reasons—firstly the inability of any fast or medium bowler to keep a steady length, the result being that too many runs have been conceded by what should be economical bowling for very few wickets. Secondly, the fielding, with of course a few exceptions, has generally looked poor, and a lot of catches have been dropped. Thirdly, only three batsmen have been at all consistent—Butchey, Cutler and Powell-Jackson.

These shortcomings can nearly all be attributed to lack of practice rather than lack of ability. We hope therefore that as we play more we shall soon be able to fulfil our true potentiality. It is a pity though that we could not have worked as hard in the nets as some of our opponents obviously did.

TENNIS

This season, C. Newman, the captain, H. Sharp, J. Siegle and P. Swiss, are four remaining players from last season's 1st VI. R. Knight is at present unable to play, and J. Boyd, the sixth member of the team, has recently qualified, and will be playing but a few games. However, many promising newcomers have arrived at Guy's, the four most proficient being J. Hopkins and R. Machell, both junior county players, and J. Newman and C. Davies from Cambridge.

In the first match of the season we soundly beat Westminster Bank 9—0, but the 2nd VI, led again by J. H. W. Davies, were beaten as convincingly by University College 2nd VI.

Reports and Results

ATHLETICS

UNIVERSITY OF LONDON CHAMPIONSHIPS

At Motspur Park 1st May, 1965

Result: Guy's won

In this meeting at Motspur Park the Hospital scored a very notable victory, the first in this event since 1939.

Again the depth of talent present in the Club was borne out by the fact that only three first places were gained, and yet the Hospital was placed first by the relatively large margin of seventeen points. This can be attributed to the fact that in only five events were Guy's not placed. Heats and two finals were held on the Friday evening, with P. Peace scoring an early success by coming second in the men's hammer.

D. Choat and J. Wheeler both ran well to qualify for the final of the 880 yds., and Alison Stevens gained a very creditable third place in the women's discus event.

P. Bundred was very unlucky not to qualify in his heat in the men's 440 yds., in spite of the fact that his time was faster than that of two others who qualified in a different heat. On the Saturday afternoon D. Osborne and P. Peace started the proceedings by coming 1st and 2nd respectively in the men's discus.

In the sprint events, D. Barford was placed 3rd in the 100 yds, and 5th in the 220 yds., with F. Nwator gaining 6th place in the latter event.

In the final of the men's 880 yds., J. Wheeler ran with a great deal of determination to finish 3rd in a very good time. Our strength in the field events was again evident with B. Hartley taking 2nd place in the men's javelin, and W. Annan gaining 3rd place in the high jump. The captain, R. Morris, was unable to jump in this event owing to an unfortunate injury two days before the championships.

P. Peace further demonstrated his versatility in the men's throwing events by gaining 2nd place in the shot-put, with R. Bailey taking 6th place. M. Bates jumped well to gain 5th place in the triple jump.

In the hurdles events, A. Winskill ran brilliantly to win the 120 yds. hurdles, and after an exciting tussle in the 440 yds. hurdles, succeeded in beating I. Morgan into first place. After a year's absence from athletics owing to injury, this was a particularly fine achievement and a fair reward for many weeks of training during the winter.

Owing to the fact that this meeting is held very early in the season, performances in individual events are never as good as they might be, but on this occasion determination on the part of all concerned contrived to give Guy's victory in this fiercely contested competition.

Result.

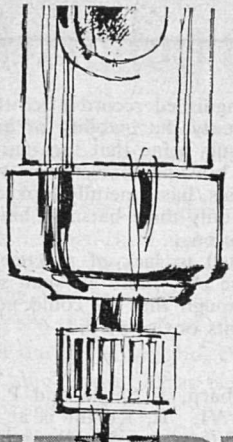
1st—Guy's, 65 points.
2nd—University College, 48 points.
3rd—King's College, 39 points.

Men

100 yds. 3rd, D. Barford.
220 yds. 5th, D. Barford; 6th, F. Nwator.
880 yds. 3rd, J. Wheeler.
120 yds hurdles. 1st, A. Winskill; 5th J. Domaingue.
440 yds. hurdles: 1st, A. Winskill; 2nd, I. Morgan.
High Jump. 3rd, W. Annan.
Shot. 2nd, P. Peace; 6th, R. Bailey.
Discus. 1st D. Osborne; 2nd, P. Peace.
Javelin. 2nd, B. Hartley; 6th, D. Osborne.
Hammer. 2nd, P. Peace.

Women

Discus. 3rd, A. Stevens.



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Guy's v. London and St. Bartholomew's Hospitals

At H.O.P. Wednesday, 5th May, 1965

Guy's, although fielding a side which was drastically depleted owing to the demands of the University athletic team, managed to win this match by a fairly comfortable margin.

Bart's dominated the shorter distance events, but Guy's scored heavily over the middle distances and in the field events.

Result.

1st—Guy's, 127½ points.
2nd—St. Bartholomew's Hospital, 84½ points.
3rd—London Hospital, 75 points.

D. BARFORD

CRICKET

GUY'S v. LLOYD'S BANK

At H.O.P. Saturday, 1st May, 1965

Result: drawn

Guy's elected to field on what proved to be a very slow wicket after the overnight rain. Knott and Beacham opened the attack which contrived to keep their opponents score to 15 in the first half-hour. Then Knott brought one sharply back off the wicket to strike the batsman's right pad—a ball good enough, and the subsequent appeal sufficiently determined to leave even the opposition umpire in no doubt. Two balls later Macgregor took his first catch of the season. There was then to ensue a stand which realised over 70 runs in just under three hours, with a long intermission for rain, tea, and the cup final. With the score at nil—all Guy's reluctantly had to take the field and resume battle. At long last the opposing captain's wicket was captured by Davoodbhoy's quicker ball down the leg side which rebounded off the wicketkeeper's knee-cap on to the stumps: Macgregor's first stumping of the season.

Declaration soon followed, and Guy's were faced with the task of scoring 129 in 90 minutes. The less said about the Guy's batting the better, save mentioning that the challenge at no time looked like being accepted, and that the only good moments were provided by Silk. Disappointing weather contributed to an undistinguished game, one which most of us will find easy to forget.

Scores.

Lloyd's Bank: 128—4. (Knott, 3—40.)

Guy's: 72—7. (Silk, 23.)

J. POWELL-JACKSON

GUY'S v. THE CRICKETS

At H.O.P. Sunday, 2nd May, 1965

Result: Guy's won by 64 runs

Against steady bowling on a difficult wicket, Guy's started off very slowly, scoring only 40 in the first hour-and-a-half. However, the patience and determination of Butchey and Powell-Jackson, together with a quick 20 from Myall at the end, enabled Guy's to declare albeit a little late at 150 for 5.

The standard of our opponents' batting did not match their bowling and fielding, and with all the bowlers sharing the wickets, they were dismissed for 87 to give us our first win.

Scores.

Guy's: 151—5 dec. (Butchey, 41; Powell-Jackson, 50 n.o.; Myall, 22.)

The Crickets: 87. (B. Deadman, 40.)

GUY'S v. HONOR OAK

At H.O.P. Saturday, 8th May, 1965

Result: Guy's lost by 64 runs

A very poor opening attack and too many missed chances allowed Honor Oak to score 60 runs without losing a wicket in the first 40 minutes. The balance was restored somewhat by Davoodbhoy who flighted his off-breaks into the wind very deceptively and took five wickets. Nevertheless, we were still set the rather substantial total of 208 runs.

The early batsmen went for the runs at once, and a fine hard-hit 50 by Hambleton, in his first game of the season, put us almost up with the clock. However, when he was caught out the rest of the innings inexcusably crumbled, and the last five wickets fell for only 10 runs.

Scores.

Honor Oak: 208. (Best, 63.) (Davoodbhoy, 5—65.)

Guy's: 144. (Hambleton, 50; Butchey, 34; Cutler, 29.)

GUY'S v. ASHTEAD

Away Sunday, 9th May, 1965

Ashtead won the toss and elected to bat.

Knott and Beacham made good use of a damp wicket, and by the end of the first hour Ashtead were 30—5, Beacham having taken four of the wickets. Their recovery was brought about mainly by their opening bat, who went on to make 98; he took full advantage of two chances that weren't accepted early on in his innings. They eventually declared at 170—8, leaving Guy's 125 minutes to make the runs. Davoodbhoy had his customary good spell, and was somewhat unlucky in only claiming two wickets.

Macgregor and Appleby opened for Guy's. Both soon departed; Macgregor being bowled, and Appleby running himself out. Cutler was caught at short-leg, and it was left to Powell-Jackson and Silk to restore the position. They came together with the score at 20—3 and put on 60 before Powell-Jackson was well caught in the deep. By now 90 runs were needed in 45 minutes, and Edgar raised Guy's hopes with a fine, aggressive innings of 35, including two very large sixes. However, with 15 minutes to go, and 35 runs still needed, four quick wickets fell, including that of Silk, who made an interesting 49. It was left to Neville and Knott to play out the last couple of overs; fortunately, they did this successfully, as the number eleven was indisposed when the eighth wicket fell!

Scores.

Ashtead: 170—8 declared. (R. Cheveley, 98.) (R. Beacham, 4—36; N. Knott, 2—29; S. Davoodbhoy, 2—57.)

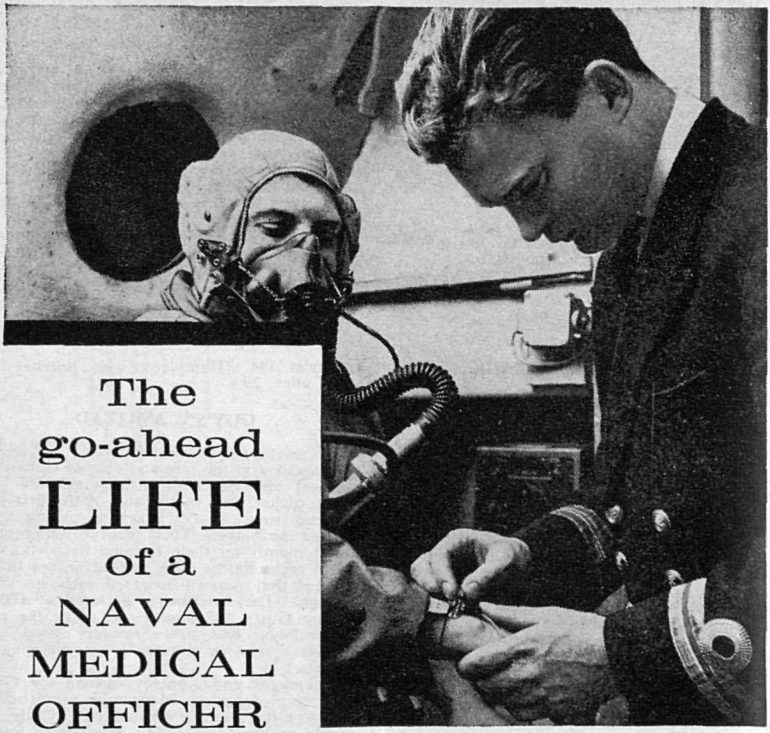
Guy's: 148—8. (D. Silk, 49; J. Powell-Jackson, 33; A. Edgar, 35.)

LADIES' TENNIS

On the week-end of May 1st and 2nd, Guy's Ladies' Tennis Team embarked upon their annual trip to Cambridge—once again scoring decisive victories over both Girton and Newnham Colleges.

This was the first match of the season, and although there had not been time for much practice, the team were in great form—beating Girton College 9—0 without dropping a set.

On the Sunday Guy's met Newnham College (a slightly stronger side), nevertheless beating them 7—2. This week-end was a most encouraging start to the season, and it is hoped that the remaining matches will carry such satisfactory results.



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The following Awards have been made:—

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A. M. Morris—Certificate

UNIVERSITY OF LONDON

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Jacqueline S. Turner
R. J. von Witt
P. L. D. Walde
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I. K. Weir
J. G. Wheeler
W. J. Wiggins
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*Have completed the examination

UNIVERSITY OF OXFORD

2nd B.M.

General Pathology and Bacteriology

S. R. C. J. Stanley-Little

Special and Clinical Pathology

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Pharmacology and Principles of Therapeutics

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NURSING NEWS

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BIRTHS

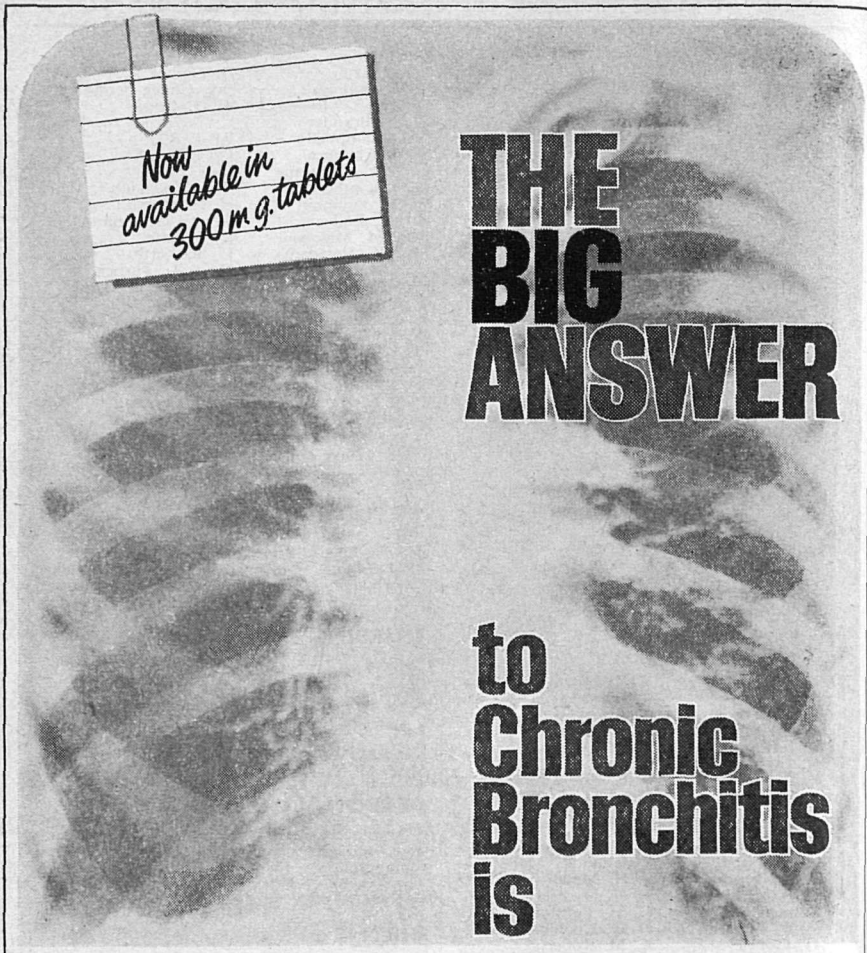
BAKER.—On the 4th May, at Nuffield House, Guy's Hospital, to Drs. Margaret and Geoffrey A. E. Baker, a daughter, Penelope Anne, a sister for Michael, Wendy, and Timothy.

O'BRIEN.—On April 10th, at the Duke of York Nursing Home, Bradford, to Shirley (née Chambers) and Patrick O'Brien, of Carlrayne, Burley Road, Menston, Ilkley, Yorks (new address), a son, Paul William, a brother for Helen, Anna, Patrick, and Christopher.

REYNOLDS.—On April 25th, at Lordswood Maternity Hospital, Harbourn, Birmingham, to Barbara (née Allen, M.B., B.S.) and Richard Reynolds, M.B., B.Ch., a son, Matthew John, brother for Sarah and James.

MARRIAGE

SHAW—CAMPBELL.—On March 27th, 1965, in Edinburgh, David James Abbey Shaw, B.Sc., to Anne Urquhart Campbell, S.R.N., S.C.M.



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GUY'S HOSPITAL GAZETTE

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EDITORS P. BOWDEN AND A. E. RAYNES

SPORTS CORRESPONDENT A. PROCTER

GUY'S HOSPITAL, LONDON

PASSIM

Drugs and Prejudice

The tragic death of an Oxford student has precipitated an unbalanced outburst from the national press, with the usual one and a half inch headlines, dubious statistics and naïve moral judgments.

The World Health Organisation committee of 1950, in defining addiction, used the phrase of "detriment to society". While this phrase is still used it should be more clearly defined and this aspect of addiction should not be confused with society's reaction to the addict. The public's attitude to indulgence in drugs for non-therapeutic purposes is greatly influenced by the prejudices of the press, which may not only be misguided but also based on completely false premises. For instance, the available evidence shows that marijuana is not a drug of addiction and has no known harmful physiological effects. It is used freely in the world of Islam where it is considered less harmful than alcohol, yet it is surrounded by social distaste in the West. Alcohol is sold freely over the counter here with little regard to its toxic or addictive effects and is tolerated and accepted. This is a social prejudice founded on lack of information.

If the use of marijuana increases in this country, as it shows signs of doing, the medical profession will be called in on a problem created by an ill-informed society rather than the drug itself. Here there is need for fresh social thinking and scientific honesty.

Escalation from marijuana does not appear to be a trend of the cult, but while it is available only through the same illegal circuits as the "hard" drugs, then it remains a distinct possibility. The cocaine and heroin addicts tend to be outcasts from even this society. They present a different problem in which the function of the doctor is clear. The effect of the law, however, is not so clear and some of the socially unacceptable traits of the addict are undoubtedly created by the illicit environment into which he is forced.

An understanding of this problem will not be achieved if the prejudice that helped create it is allowed to influence the approach of the investigators. The public might also be spared the fabrications of the gentlemen of Fleet Street who would do well to extinguish their cigarettes, look into their whiskies, and think again.

Nature

When travelling through England, contemplating the world across opaque British Railways glass, one of the most striking things is the tidiness and expanse of the countryside. Town-life makes one think town-wise and everything is hooting horns and scurrying people and even nightfall brings no relapse. As soon as the city is left behind, the emptiness of the country is even more startling and obvious, life being slower and more amenable with shifted emphasis, population

problems seem very far away and the seamy side and Rachmanistic exploitation appear to be the price paid for a metropolitan life with all its conveniences.

Once a learned authority, giving a talk at Guy's, stated that, scientifically, man could subsist on the produce of ten square feet of earth, this was part of an anti-population control argument. To reduce *ad absurdum* one can envisage *homo sapiens* (self-named with modesty) fenced into his quota and being liberated once every seven years like the Sphinx of Wild West Show fame, or to banishment like the Savage of Brave New World. We may even reach the stage of destroying nature because we do not understand it and the Kingfisher will join the pigeons in Trafalgar Square. It is important that man living in cities should have the opportunity and availability of countryside if only to release him from his clockwork life, so that he may give nourishment to the freedom of his soul. When agriculture has achieved its limit, in yield per acre terms, then perhaps more land will be available not for slumming or growing apples in sheds like mushrooms and chickens but for his leisure and enjoyment. Town and country life each have their assets but one feels that the former is engulfing the latter so that it may achieve its own avaricious expansionist ends.

The very existence of a National Trust points to the fact that we are unable to preserve our own heritage, many times it has saved land and monument from the auctioneer's unscrupulous hammer. The fortunes of our most picturesque places lie solely in the generous hands of the dying. There should be green belts whose integrity is inviolable and development committees should unite to govern whole towns' future, not that of plots.

We offer our congratulations to Dr. S. De Nevasquez, on whom the title of Professor of Morbid Anatomy has been conferred by the University of London.

GUY'S DIARY

MAY.		
31st M.	1.00	Dr. M. J. McARDLE. Clinical Lecture.
JUNE		
1st T.	1.00	Professor ATKINS. Clinical Lecture. "*Acute Haemorrhagic Pancreatic Necrosis.*"
3rd Th.	1.00	Professor RUSHTON. Clinical Lecture. "*Teeth of Unusual Appearance.*"
10th Th.	1.00	Dr. DOW. Clinical Lecture. "*Dissecting Aneurysm of the Aorta.*"
11th F.	1.00	Mr. BRAIN. Clinical Lecture.
14th M.	1.00	Mr. CRABBE. Clinical Lecture. "*Malignant Tumours of Bone.*"
15th T.	1.00	Dr. MANN. Clinical Lecture. "*Diarrhoea.*"
18th F.	1.00	Professor BUTTERFIELD. Clinical Lecture.

THE IMPORTANCE OF THE FAMILY DOCTOR TO SOCIETY

HARRY N. LEVITT

Dr. Levitt is a general practitioner in Marylebone. He has been in practice in the same street for close on thirty years (except for six years' absence on service). He is a Foundation Member and Chairman of Council of the College of General Practitioners.

Opinions and decisions on general practice and family doctors are often made on the basis of unproved assumptions and incorrect or insufficient information. Corrected statements or facts do not guarantee necessary action when these collide with prejudice. A brief historical survey of our society and the health services over the years is necessary for an understanding of the present National Health Service. The pattern of disease is changing rapidly because of the better control of the physical and biological environment. This survey will try to contribute some understanding of the evolution of personal medical care. It is agreed by the majority of those who have studied this problem in the Western World, that care in the community is one of the fundamental debates of our time. This may reflect differences in social and political philosophies, but all are agreed on the importance of the work of the personal or family doctor in our society. How to translate this into practical measures is what constitutes the problem.

Up to the commencement of the eighteenth century the State took very little interest in the health or welfare of the individual. Medieval medicine divorced from every-day life made little advance. Not until the seventeenth and eighteenth centuries, when enquiry and observation began to displace tradition and custom, did real progress in medicine and science take place. The great changes in social structure of the eighteenth century were due to invention of machinery and the rapid expansion of the factory system in industry. Outbreaks of cholera and typhoid fever were frequent and these created terror and havoc. New towns were unable to handle the problems of gross overcrowding, insanitary housing conditions, and there was lack of supervision of the fresh water supply. This was the century of high mortality in the operating theatre and in childbirth.

The general practitioner of the time might be called to deliver a woman in the same room in which a corpse was lying. The family were saving up to bury the body and avoid the stigma of a common or pauper's grave. In the simplest care of sick persons at home there was more often than not no bedding and no access to running water. In the dingy, overcrowded courts, there would be one cold water tap for the

This article is based on a lecture, originally given at Goldsmith College, in the series "Towards Better Medical Care."

whole building. Isolation was impossible when families lived eight or ten to a room. There was little the general practitioner could do to ameliorate these terrible conditions, despair and defeatism rivalled ignorance and stupidity.

In 1858, the same year in which the General Medical Council was established, the activities of the General Board of Health came to an end. The powers of the board were transferred to the Privy Council with Dr. (later Sir) John Simon as medical adviser. Simon was the first Medical Officer of Health for London and his appointment dated from 1848. His annual reports and "Reports on the Sanitary Conditions of the City of London" are vivid and graphic pictures of the social and sanitary conditions of his time. He was a man of enormous energy, vision and drive. In his *English Sanitary Institutions*, we can trace the historical development of hygiene and read his careful description of epidemiological studies. These studies laid the foundation for investigation into communicable disease and measures for prevention. Outbreaks of diphtheria were investigated, as well as famine disease, typhus fevers, cerebro-spinal meningitis and cholera. New facts were obtained about infantile diarrhoea, tuberculosis and bronchitis. Above all, it was Simon who tried to persuade the government to recognise the importance of research into matters of health and disease. On the work of Pasteur, Koch and Klebs the modern treatment of infectious diseases is based. These three great pioneers at this period in time gave the great stimulus to bacteriological research. It was Pasteur's work which led to Lister's application of antisepsis and the prevention of wound infection. This lowered the risks and hazards of surgical operations. In the field of industrial hygiene, many of the improvements in health were initiated by the Factory Acts. These aimed at improving conditions of employment in the mines, mills and factories; they reduced the number of hours that could be worked by women and young children.

Throughout this ferment of intellectual and clinical activity, the general practitioner worked in professional isolation. All this wealth of information should have been available to him and its impact on the practice of medicine in the community would have been enormous if medical care had been organised. The time for this was not yet ripe. There was a great gulf between the medical officers of health and general practitioners. This was evident in the nineteenth century and continued well into the twentieth century. There were very few exceptions when the two branches of the profession could work in unison. Even the teaching hospital staffs looked down on the public health doctors and considered community medicine or public health as a field for mediocrities. There was a complete failure to recognise the fact that good preventive medicine derives from good clinical medicine. There was too much emphasis, it was thought, on environmental hygiene to the exclusion of clinical medicine. There was suspicion and anxiety of interference in clinical matters by local authorities, who were of course advised by their medical officers of health. There was the underlying fear of bureaucratic control and interference with professional freedom. There was the intense individualism of the general practitioner, who was compelled to rely entirely on his own initiative and efforts for care of his

sick patients. These are the historical facts which have laid the foundation of the present-day antagonism and suspicion of State intervention in the organisation of medical care and the prevention of disease. The general practitioner of the time was largely deprived of clinical support from the hospital and public health department. They could not help those riddled with tuberculosis living in crowded dwellings. They could not help the sick and poor and broken in spirit, discarded by the industrial machine of the factory system.

Some of those in authority began to recognise the problem of care of the individual and his family in the community. It had been established that gross physical ill-health was related to control of the environment. Young women, pregnant women, infants and children and young adults were the vulnerable members of society. The infant mortality rate was 149 per thousand live births (22 in 1962). The expectation of life for a woman was 46 years of age and 41 for a man, compared with the 1962 figure of 71 years for a woman and 68 years for a man. A public conscience was only just beginning to acknowledge the close association of poverty with sickness and unemployment.

The years 1875—1900 covered a series of progressive reforms concerned with improvements in environmental hygiene and health. Later reforms supervised local government action related to public health and relief of the poor. Voluntary organisations dealing with poor relief, housing and sick visiting supported the work of the government and in some instances received financial help through grants from Local Authorities.

At the end of the 19th century, vast improvements had taken place in general sanitary conditions in the large cities and towns. Streets were improved with better drains and sewers and there was a better fresh water supply. The black spots were large areas of unfit dwelling-houses, slums of the worst kind, particularly in the Midlands and over-populated industrial areas. Epidemic diseases were on the wane except for the dreaded diphtheria, scarlet fever, whooping-cough and tuberculosis. Mortality rates were reducing except for the infant and maternal mortality rates. Atmospheric pollution was increasing with the growth of heavy industry, especially coal-mining. Bronchitis, the "English Disease", was not yet the fourth major cause of death in Britain.

The nation was shocked to read that almost 40 per cent of recruits for the Anglo-Boer War were medically unfit for service. A committee was set up to examine the causes and the report made important recommendations in the setting up of personal health services and also stimulated interest in problems of social medicine. (John Ryle was the first such professor when he was appointed, in 1943, to the newly-instituted Chair of Social Medicine at Oxford.) 1906 saw the introduction of meals for children in primary schools. 1907 the School Medical Service was created. Henceforth there was to be periodic examination of school children and free treatment of minor defects. But it was not until 1915 that notification of births became a compulsory act. In the early 1900's the infant mortality rate was about 150 per thousand live births. Maternal and still-birth rates were still high. Notification of births assisted the public health services in developing infant care services, but it was not

until 1918 that Local Authorities were legally obliged to provide Maternal and Child Welfare services, and the training of midwives.

In 1919 the Ministry of Health was created to control the many health functions that were formerly administered by several bodies. The governing body of the day also concerned itself with improvement in venereal disease service and in particular with the problems of increase in incidence of mental deficiency.

The 1914-18 War stimulated house building which was accelerated in the early twenties with active measures of slum clearance, and this was halted by the slump of the 1930's. The Local Government Act was introduced in 1929. This was the end of the Poor Law System introduced in the reign of Elizabeth I, 1601. It is interesting to quote the main objectives of this Act. It made it compulsory for relatives to maintain their own poor. All fit persons were expected to work for relief of their poverty (the "Workhouse"). The "sick poor" without relatives were a charge on the rates of the local parish. This system lasted until the Industrial Revolution, which rendered it unworkable and harsh in its application.

What was happening to the general practitioner since 1900? In 1911 the first National Health Insurance Act was introduced in Parliament by Lloyd George and the Liberal Party; it provided for some insurance "against loss of health and for the prevention and cure of sickness" of insured workers. It did not cover dependents. Many of the workers banded themselves together in a Friendly Society or Sick Club and subscribed between a penny and fourpence a week. The original intention was to save sufficient for burial in the event of death and avoid the stigma of a pauper's funeral and being buried in unconsecrated ground. Later a limited form of advice with a bottle of medicine was added for some members of the family of the insured man. General Practitioners were engaged by contract to attend to members of a Friendly Society or Sick Club. The amount of remuneration varied between twenty and seventy pounds per annum. In some mining areas, Societies or Lodges, ten shilling and sixpence was the fee for attendance at childbirth. This kind of practice among the poor carried on until the introduction of The National Insurance Act. A General Practitioner now had insured patients on his register or panel by contract with the government. He received a fixed income depending on the number of patients, which was not allowed to exceed a certain figure. This was the Capitation Fee.

The 1929 Local Government Act virtually placed curative and preventive health care in the power of the Medical Officer of Health. The County Councils took over the Poor Law Hospitals and these became the Municipal Hospitals.

In 1938 the Emergency Medical Services were set up to organise medical services for the nation to meet the impending threat of war which finally involved Britain in September, 1939. All medical services were pooled and zoned, which meant a radical alteration of the National Health Service and a return to the former system was most unlikely. For the first time in the history of health care in Britain, the dependents of insured workers were entitled to a limited and defined amount of care, financially sponsored by the State.

The bulk of care of patients in the community was left to the general practitioner. There were still many patients who did not qualify for treatment under the new regulations. The general practitioner did not have direct access to hospital or clinic. Both he and many of his patients were left out in the scheme of organised care, in spite of the fact that suggestions had already been made about Health Centres for organisation of care in the community. In 1920, Lord Dawson, one of the medical peers, outlined a plan for Health Centres from which good community care could be practised.

In 1941 Lord Beveridge outlined a plan under which the whole of the population, irrespective of income, would be entitled to medical care at home or in hospital to be paid for by the State. There was to be greater emphasis on preventive medicine.

In 1943, during a debate in the House of Lords, Lord Moran outlined his idea of group practice " . . . if doctors, instead of practising in their own houses were to be banded together, eight or nine doctors, and were to see patients at some house built for the purpose, with facilities for diagnosis and with consultative services at their elbow . . . it would be a great gain to the community. . . ." The National Health Service Act was established on 5th July, 1948. In spite of its severest critics, it is recognised as the most civilised piece of social legislation of the century. For the first time in history every man, woman and child is legally entitled to the services of a personal doctor, without any "ifs" or "buts". This ideal of a personal doctor for the common man is a comparatively new concept.

It is against this social and economic background, sketched out in brief, that we are now able to appreciate and see more clearly what the problems are in personal medical care. It is becoming clear with the enormous advances in surgery and medicine and the ancillary medical sciences, that no one man can master the whole field of Medicine. In the previous century, the specialist field had embraced mainly the eye, ear, nose and throat men, and obstetricians. Specialities have now multiplied so rapidly that a general physician or general surgeon is a rare bird. The task of medicine has become more and more a social science, the main task of which is to keep people socially adjusted to their environment or to re-adjust them if their health has broken down. The five main tasks are, promotion of health, the prevention of illness, the early detection of disease, to treat the sick when prevention has failed and to rehabilitate those who may require special care after specific treatment. Much of the maladjustment in our society to-day is due in large measure to the neglect of sociology in medicine.

In all of the five tasks of health care the family doctor plays an important role. The kind of care envisaged in these tasks is continuous. It cannot be adequately or properly provided from the out-patient department of any hospital, or from the department of the Medical Officer of Health, nor can it be successfully carried out by the general practitioner: except in a team which originated from or developed from community social services. The general practitioner is a man or woman trained in medicine, who assumes a certain proportion of total continuing care of the individual. Whereas the hospital, by virtue of its specialist

nature, is a highly organised "consultant-unit". It is not organised in such a way as to be as easily accessible as the general practitioner. The hospital out-patient system fragments the patient. He cannot be seen as a whole person except, perhaps, in the paediatric or psychiatric department. On an average there are about thirty-six departments concerned with a different clinical system or specific organ or particular age group. In general practice the patient is seen as a whole person in relation to his family and to society. The first concern of the family doctor is the sick person and his family, not the illness. In the surgery of the family doctor, medicine and society meet. A group or collection of specialists cannot treat or communicate with an individual. From the patient's point of view it is the need to know whose judgment he can trust. From his experience he has to be able to distinguish the charlatan from the genuine article, the reasonable and instructed doctor from the unreasonable and uninstructed one. The family doctor of the future will meet a more demanding and critical public. Higher standards of living and of education in Britain as a whole, and a more sophisticated adult population are not going to accept lower standards of medical care and service. In the long run, "an educated public opinion is the most powerful ally of the medical profession". When the patient chooses a doctor, he has to judge the doctor as an individual with a difference, he has to decide whether he can trust the doctor to trust other men and other doctors. There is a whole "pyramid structure of trust" involved when you choose your personal doctor. You trust him to choose the proper and correct specialist for a second opinion, you trust him to chose the appropriate surgeon to deal with the clinical problem; you trust him to choose the best oculist for your vision. I need not labour the importance of this trust. You are, in fact, relying on his judgment to choose well for you and yours. When the patient through illness gets into the web of medicine, he needs well trained and qualified specialists who have made it their lifetime study to bring skill and judgment to their work. But he needs above all a personal doctor who can speak his language, one who can interpret the hospital and the specialist to the patient; one who is interested in him and knows his history and social background in depth and can translate the patient's needs and fears to the hospital. This is one of the most important roles of the family doctor. He shields the hospital and insulates its staff from excessive demands for care. He visits patients in their homes. He advises the Medical Officer of Health and through him manipulates the social services for the benefit of the sick patient or the family.

It is as well to recall that between 80 and 90 per cent of all illness is taken care of in the community and the hospital only treats about 10 per cent. One of the most important factors likely to affect the family doctor and the hospital is the enormous increase in the population. It is stated on good authority that the population of England and Wales will reach 54 million within the next twenty years. According to the Registrar-General we are likely to have well over a million more people over the age of 65 within the next ten years . By 1972 we are likely to have one million people who have passed their 80th birthday. About one-third of this additional population will be 75 years and over. Seven

per cent of this increase, nearly all women, will be 85 years of age and over. The Gillie Report on the Field work of the General Practitioner, said that the needs of the aged will represent one of the central problems of general practice.

When the patient returns to his home from the care of the hospital there should be an extension of medical, social and, if necessary, psychiatric care of the patient. We have concentrated too long on scientific care and assumed that the application of its results was all that was needed. It did not; and the technology of medicine has outrun its sociology. We have lacked a proper balance far too long between curative and preventive medicine. Preventive techniques are actions which the family doctor rather than the patient initiates. This work depends on a factual knowledge of the patient and his family. It requires a knowledge of the vulnerable members of the community. The pattern of medicine has changed enormously in the last fifty years, even in the last twenty years. It calls for the co-operative efforts of general practitioners, specialists, for the wide use of hospitals and the public health services. (Guy's Hospital are doing pioneering work in this field.) General Practice is right at the frontiers of clinical medicine. There is still a large number of unsolved problems. More people die from the diseases of maturity and old age. Diseases of heart and circulation, especially of middle-aged men, have the highest mortality. There are the collagen diseases—the "wear and tear diseases"—which disable so many in old age. Medical science has more to give than people receive. "In the civilised society of to-morrow every family will have not only its family doctor but also its family health centre from which it will be entitled to receive all the advice and help it may need. This will shift the emphasis from disease to health."

Each generation must write its own history and draw its own deductions from that already written; not because the conclusions of its predecessors are untrue but for practical reasons. Different answers are required because different questions are asked. I have tried to describe the historical background of our Health Service. We have noted the indifference of the State to the health of the individual before the 17th century and the gradual recognition of the need for care in the community of the family at the present time. Internal medicine has only recently developed its power but this is increasing rapidly. A personal physician for every person is of recent origin, the 5th July, 1948, to be exact. There is need of a medical friend for every patient. He should be a particular kind of doctor; one who is able to deal with clinical problems, with social problems and undifferentiated general problems. I believe him to be the family doctor.

Our failures as human beings lead some of us to the mistaken conclusions that progress is a mirage. Although we find much to depress us, much remains to cheer us.

Guy's Hospital Science Club A.G.M.

The Annual General Meeting of the Guy's Hospital Science Club will be held on Wednesday, 9th June, at 4.45 p.m., in the Staff Common Room of the Medical School. Members of the teaching and research staff of the Hospital and Medical and Dental Schools are invited. Tea will be served at 4.30 p.m.

R. O. WELLER, *Hon. Sec.*

THE DOCTOR AND THE HANDICAPPED NEWBORN

R. W. SMITHELLS,

CONSULTANT PAEDIATRICIAN AND MEDICAL SUPERINTENDENT
ALDER HEY AND OLIVE MOUNT CHILDREN'S HOSPITALS, LIVERPOOL

The doctor who first recognises a congenital defect carries heavy responsibilities. He is usually the person to diagnose physical handicaps because these are likely to be obvious at, or soon after, birth. In contrast, mental handicap may be initially recognised by parents, relatives, neighbours, nurses or teachers. The doctor's first responsibility to any handicapped child is to be certain that his diagnosis is correct. With remediable disorders such as intestinal obstruction and congenital hypothyroidism, the importance of early and accurate diagnosis is obvious. When the condition is not amenable to treatment—as, for example, mongolism—it is just as important to be certain of one's facts before telling parents that their child will carry a handicap through life.

Diagnostic doubt may arise about newborn babies suspected of being mongols or of suffering from congenital heart disease. The diagnosis of mongolism is usually certain on clinical grounds, but there are occasional instances when real uncertainty exists. It is quite unjustifiable to inform parents that their child *may* be a mongol. If the doubts cannot be resolved on clinical grounds, chromosome studies should be undertaken at the first possible moment because these will place the diagnosis beyond a peradventure. The parents can then be given definite information and can be saved from unnecessary worry which would be caused if the provisional diagnosis proved to be wrong.

In the case of congenital heart disease it is sometimes difficult to interpret a heart murmur heard in an otherwise healthy newborn baby. Radiographs and electrocardiograms may be of little help. The true significance of the murmur may only become apparent after a follow-up period of weeks or months. It is often possible to find some pretext for arranging follow-up visits for these children, and the existence of the heart murmur may not have to be mentioned until such time as the diagnosis of a congenital heart lesion is certain. Many of the murmurs heard in the neonatal period disappear in time and in these instances the mother need never share the doctor's anxiety.

When the diagnosis of the congenital handicap is certain, it is the doctor's responsibility to explain to the parents the nature of this handicap and try to give them some idea of what can be done about it in the time ahead. It must be remembered throughout the interviews that any defect, however small, will appear far more serious to the parents than it does to the doctor. Even so, the very minor anomalies such as vascular birth marks and skin tags on the hand or by the ear can be shown to the mother without delay, and an explanation can be given that the birth mark is likely to disappear of its own accord in time, or that the skin tag will be ligated.

When a congenital abnormality demands urgent surgical treatment there is no option but to inform the parents at the earliest possible moment so that they may know what is happening to their child, and can give the necessary parental consent for whatever treatment is necessary. There remain a number of major handicaps for which urgent treatment is not required, so that the doctor can to a certain extent choose the time and circumstances in which he will speak to the parents. With a deformity that is apparent, such as a cleft lip, there can clearly be little delay. The appearance of a cleft lip can be very distressing to the parents, particularly if the lesion is bilateral. It is as well, therefore, to warn the mother of it before she sees the baby. It can be explained to her that the defect can be remedied by operation, and it is extremely helpful to be able to show her photographs of a similarly affected child before and after operation. (Figs. 1—4). This demonstration of what will be done for her child will give her the necessary encouragement to love and to care for him during the waiting period.

The greatest difficulty for the doctor arises when it falls to his lot to break the news of a mental handicap. This can only be recognised with certainty at birth if the baby is a mongol or a microcephalic idiot. This information must be conveyed with as much skill and sympathy as the doctor has at his command. A mother's emotions in the first few days after delivery are often extremely labile and it is as well, if possible, to avoid breaking bad news during this time. There is much to be said for speaking first to the father, and later to both parents together. However carefully the diagnosis and its implications are explained, it must be expected that very little of what the doctor says at the first interview will be remembered, and much of what is remembered is misinterpreted. It is therefore essential that the parents should be interviewed again within the next few days. They will want to know what the future holds for their child and it may be impossible to answer this in more than the most general terms in the case of a newborn mongol infant. They will want to know what can be done for the child by the doctor, by themselves and by other individuals and organisations. They will want to know at some stage whether the deformity or disability in this child is likely to occur again if they have further children.

When much can be done and the ultimate prognosis is good, these questions pose no difficulties. If surgical intervention or medical treatment are indicated, the nature of these and the age at which they are likely to take place can be indicated to the parents. When a congenital abnormality conveys both a functional and a cosmetic handicap, such as, for example, congenital amputation of one forearm, the doctor will naturally think principally in terms of the functional handicap and the ways in which this may be overcome. It may come as a surprise to him that the parents seem to be more concerned about the appearance of the limb than the more practical consequences. We have to remember that each baby represents a personal triumph for its parents, and one of the first duties of any infant, particularly a first-born, is to be shown off to admiring relatives and friends. On the

other hand the new baby is not expected to do anything for himself, and it is for this reason that the baby's appearance looms so much larger in the parental eye than his functional capabilities. This difference of attitude may make the doctor's task more difficult, but may, on the other hand, be turned to his advantage.

It is more difficult in the case of the absent hand because at present a simple gripping device such as a split hook is often functionally better than any prosthesis that looks like a hand. It is, however, far less acceptable to the parents. On the other hand the parents of a child born with myelomeningocele may be more concerned about the appearance of the back than about the neurological disturbances of the legs and sphincters. The doctor can give a far more confident prognosis about the final appearance of the back than he can about the ultimate power of the legs or control of the sphincters. If there is a likelihood that the child will remain disabled throughout life, as, for example, in mongolism and myelomeningocele, it is impossible to give an accurate prognosis at birth or soon afterwards. It is only possible to define the limits within which progress is likely to be made. It is often pointed out how unkind it is to raise false hopes in the minds of parents, but it is surely equally reprehensible to deny them justifiable hopes. A mongol child may ultimately have an I.Q. anywhere between 20 per cent and 80 per cent. There is no harm whatever in parents hoping that their child will achieve the upper end of this scale.

Most parents hope that their healthy children will be a little quicker than average to talk and to walk, a little taller or stronger than average, will do rather better than average at school and throughout life be in the top half rather than in the bottom half. If this is a normal and permissible attitude towards healthy children, how much more so when the child is handicapped? This is not to say that parents should be led to believe that their mongol child *will* go to school, or that their child with myelomeningocele *will* run and jump and ride a bicycle, but equally it should not be withheld from them that these things are possible. It is this hope for the future that may be the only link between the handicapped infant and his parents until he has been with them long enough to establish his personal place in the family group. If later events prove that their past optimism was not entirely justifiable he may by then be accepted for what he is, rather than for what his parents hoped he might be.

One still hears medical people referring to severely handicapped children as "hopeless cases". We should be quite clear that the hopelessness is in the hearts of these doctors. The parents are never without hope and must not be deprived of it. Another phrase which should never cross our lips is "nothing can be done". It is often true that nothing curative can be done or that much may be done with little effect, but even in these situations something can be done. There is a great danger, if the doctor says that nothing can be done, that the parents will take the child elsewhere, and may in this way go from doctor to doctor, from clinic to clinic and even from country to country, until they find someone who says that something can be done. Such a person may be an honest and able clinician, but alternatively

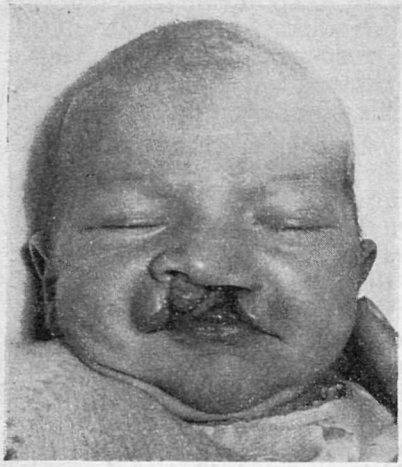


Fig. 1. *Before Treatment*

Fig. 2. *After Orthodontic Treatment*

Fig. 3. *Shortly After Operation*

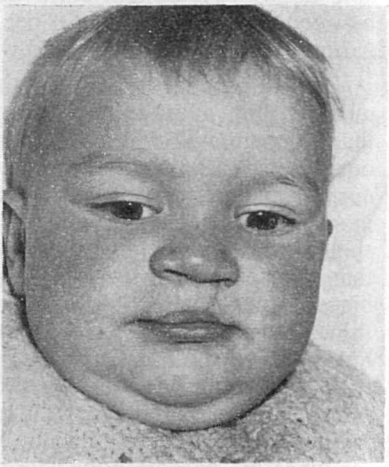


Fig. 4. *One Year Later*

Stages in the Treatment of Cleft Lip

(Photographed by Courtesy of Dr. W. D. Dunston)

he may be a person whose optimism proves to be an expensive substitute for qualifications, experience and integrity.

One of the most important things that parents can do for any handicapped child from the day he is born is to give him as normal an upbringing as is possible. Not only does his body need to be nourished; he also needs to be cherished. It has been clearly shown

that healthy babies deprived of the normal sensory stimuli from their environment fail to develop normally and become entirely divorced from the world around them. Just as growth is a series of responses to hormonal stimuli, so mental development is a series of responses to social stimuli, to sights, to sounds, to skin sensation and to a feeling of being loved and secure. There is clearly a limit to the extent to which a child with a very severe mental handicap can respond to any stimuli at all. However, what is beyond doubt is that without these stimuli no child, healthy or handicapped, will develop to his fullest capacity. This is something which every parent can do for his handicapped child, which costs nothing, and which often pays handsome dividends.

The child whose handicap is purely physical is at a disadvantage to this extent, that he is aware of his handicap and of the fact that he differs from the majority. This situation must be handled mainly by the parents, although the doctor may be able to give guidance. It is often a matter of delicate judgment to know when a handicap should be ignored, and when allowances must be made for it; to know how much the handicapped child can be expected to do for himself, so that he becomes less aware of his handicap and not more conscious of it.

In addition to their own efforts and the help that they can gain from their family doctor and from the hospital team, parents may also derive help from a number of statutory and voluntary organisations. One of the most valuable assets to any community is a day nursery for mentally handicapped children. Some are run by statutory bodies and others by voluntary organisations. They fulfil the dual functions of relieving the mother of a heavy burden for part of each day, and of enabling the child to mix with other children of the same age and to begin to develop a social sense. Young children with severe mental or physical handicap frequently have no contact with children outside their own home. Their mothers may be reluctant to expose them to physical dangers and possible ridicule. The neighbours may forbid their children to play with a defective child. A day nursery may thus provide a meeting ground which is not available elsewhere. Some parents are helped by being able to meet other parents of children with similar handicaps in order to discuss mutual problems and experiences. National organisations now exist for the parents of mentally handicapped children and for children with cerebral palsy, muscular dystrophy, spina bifida and hydrocephalus, fibrocystic disease of the pancreas and deformities caused by thalidomide. Local branches of these organisations are to be found in most centres.

Finally, the parents of a congenitally abnormal child will want to know the likelihood of recurrence in future children. If the handicap is severe they may well feel at first that they will not even consider the possibility of having further children, either because of the fear of recurrence or because they wish to devote themselves exclusively to the care of their handicapped offspring. It is as well, however, to offer them an opportunity of discussing the risks with someone

experienced in genetic counselling. Non-medical people believe that hereditary factors are to blame far more often than is the case. It is, therefore, often possible to dispel unnecessary fears about the likelihood of future children being affected. At this interview an opportunity can conveniently be taken to ask the parents' own views of why this deformity occurred. They have often reached tentative conclusions, usually involving events which took place so late in pregnancy that they could not possibly be related. A deep sense of guilt and personal responsibility is usual in the parents of the abnormal child. This may be because the pregnancy was unwanted and the mother had made some attempt to terminate it, but the general anxiety has been considerably increased since the teratogenic properties of thalidomide were recognised. It is no help to a handicapped child for his parents to go through life feeling that something they did, or failed to do, was responsible for his defect. It is as much for the child's sake as for the parents, that their own ideas about causation should be explored, and that they should, as far as possible, be made to feel that no shortcomings on their part were responsible for the handicap.

These, broadly speaking, are the responsibilities of the doctor towards a handicapped child and his parents during the early days and weeks. The parents will undoubtedly need the continuing support and advice of a medical person throughout the child's life. The man best placed to provide this support is the family doctor and there is no doubt that this responsibility falls squarely on his shoulders. Sometimes, it must be confessed, the general practitioner may be unable to find the time or may lack the inclination to perform this function. In this case the hospital service must step into the breach, and it is usually to the paediatrician that this task falls. It can, however, be performed by any doctor who believes that there is more to medicine than prescribing drugs and performing operations, and whose philosophy of life is one of patient optimism.

Student Prizes and Travelling Fellowship in Psychiatry

The Mental Health Research Fund awards annually to Medical Students and Doctors in their Pre-Registration Year three Monetary Prizes and a Travelling Fellowship as the result of an essay competition on a subject relating to mental health, and a subsequent interview. Applicants gaining the top three places in the essay competition will be given prizes of £100, £50 and £25 respectively.

The Travelling Fellowship, tenable in a Psychiatric or other Department abroad for up to one year, will be awarded as the result of an interview combined with consideration of the candidate's undergraduate record. Persons interviewed will be chosen from the top ten in the essay competition. The travelling fellowship will normally be taken up at the end of the pre-registration year or, in the event of it being awarded to a medical student, may be taken up after qualification.

The subject for the essay this year is " A young adult entering hospital for treatment of a mental disorder has now much greater chance of being returned to the community in a short space of time than he had thirty years ago. Discuss the reasons for this and its effect on patient and community." The Panel of Examiners consists of two members of the Research Committee of the Mental Health Research Fund and one member of the Association of Teachers of Psychiatry in Undergraduate Medical Schools. Essays should be sent, before 1st March, 1966, to the Secretary, Research Committee, Mental Health Research Fund, 38, Wigmore Street, London, W.1 (Tel. WELback 4103), from whom further details may be obtained.

MUSIC & EVERYMAN

G. L. DAVIES

In his *Republic,* Plato puts forward the plea that the Guardians of the State should not only be true philosophers but should be chosen also because they have a musical, regular and harmonious disposition. Plato thus recognises the humanising effect of music, and so much more do we recognise this to-day that we look askance at people who tell us that they are not interested in the subject, and that music makes no appeal to them. Few though such people may be, we somehow regard them as being unnatural and not in keeping with the comity of the human race generally.

There is no doubt a revival in the love of good music to-day. Even those so-called "pop" singers who, two or three years ago, seemed merely to oscillate between a low note and a high note seem now, as the poet Pope said of someone, to be "deviating into sense", and to be giving up "pop" in favour of what they call "trad" and, so far as I am concerned, they cannot make the change quickly enough. The modern troubadour with his guitar and singing of his "heart" (so very conducive to switching off the "set" as soon as his shaggy head appears) seems nevertheless to have the root of the matter in him, in that he is sheering away from mechanized music. Another pointer in the same direction is the increasing popularity of Clubs in the North where people are now abandoning their TV sets to get together and listen to "live" performances in the style of the old music hall. We learn, too, that the sale of pianos is increasing. Those of us who are old enough will remember that the piano was once almost a *sine qua non* in a house of any standing, and that to learn to play the piano was regarded as an essential part of the education of at least the female members of the household. So much in those days was the piano a kind of status symbol that, during the 1914 war, munition workers were reputed to buy pianos which they could neither play nor sometimes even get into their houses.

Generally speaking, one may perhaps suggest that music can be all things to all men; but, narrowing its effects down, one can perhaps say that its main effects are (a) sedative, (b) stimulating and even at times (c) minatory. That once eminent French critic, Jacques Rivière (1886-1925) said, "Feelings are the objects that must be expressed in music." Debussy, a counterpart of the great Impressionists, expresses feeling in composition. His *La Mer* is the supreme example of impressionism in music, and this was preceded by *Pelléas et Mélisande,* and was a reaction against the Wagnerian conception of music in particular and Romanticism in general. His *La Mer,* to my mind, corresponds

closely to what is known as the "Stream of Consciousness" in literature, in that our thoughts ebb and flow with the sound of the music.

Most people, however, look to music for its sedative effect and some seem to find adequate satisfaction in Palm Court Orchestras and such-like. Whatever may be the source, it perhaps helps them to forget present cares with its languorous nostalgic melodies.

References to the soothing effects of music are countless in the poets. Perhaps I may be allowed to give two. One from Herrick :

> " And ever against eating cares
> Lap me in soft Lydian airs"

says Milton's *L'Allegro*. For various esoteric reasons, incomprehensible to the ordinary music lover, this kind of music rouses the ire of the musical pundit, who will even condemn some of Elgar's and Tschaikovsky's melodies as coming far short of the highest standards of musical composition, as no doubt they do here and there.

" To Musique, to Becalme the Fever".

> Charm me asleep, and melt me so
> With thy Delicious Numbers
> That being ravisht, hence I goe
> Away in easy slumbers."

And another from Christina Rossetti :

> " . . . Let a distant stream
> Of music lull me, languid as a dream,
> Soft as the whisper of a summer sea."

In leaving this one particular effect of music, perhaps one might note an entry in Pepys Diary for 12.6.1661 :—

"At home practising to sing, which is now my great trade"—(and perhaps a change from some of his other more frivolous activities).

One has only to think of all kinds of martial music as examples of stimulating music. Burton says somewhere: "Music is a roaring meg against melancholy, to rear and revive the languishing soul" and he should certainly have known, having made such a profound study of melancholy. Elgar's *March of Pomp and Circumstance* might be regarded as a fine stimulating piece of music, filling most of us with patriotic fervour, but the pundits no doubt with melancholy.

To think of music as containing a minatory significance is perhaps unusual; but one has only to call to mind how the first few bars of Beethoven's Fifth Symphony used to float out over the air during the war with their insistent threat to the enemy of inevitable defeat and overthrow. Somehow these few notes beating out their remorseless message always reminded me of Francis Thompson's poem, *The Hound of Heaven* :—

" I fled Him down the nights and down the days :
I fled Him down the arches of the years :
I fled Him down the labyrinthine ways
Of my own mind.

Still with unhurrying chase,
And unperturbèd pace,
Deliberate speed, majestic instancy,
Came on the following Feet
And a Voice above their beat,
' Naught shelters thee ' . . ."

The war drums of savage tribes and the sort of music performed as they danced around some sacrificial victim can have roused nothing but fear in onlookers and victims alike.

We all know what music is and the effect it has upon us, but it is almost impossible to define it. The Ancients spoke of the music of the spheres and Dryden seems to echo this in his *A Song for St. Cecilia's Day* :—

" From harmony, from heavenly harmony,
This universal frame began . . ."

Then he goes on to elaborate the power of music :—

" What passion cannot Music
. . . . . raise and quell?"

and so on.

Perhaps the last word may be left with Heine :—

" Now, what is music? This question occupied me for hours before I fell asleep last night. Music is a strange thing. I would almost say it is a miracle. For it stands halfway between thought and phenomenon, between spirit and matter, a sort of nebulous mediator, like and unlike each of the things it mediates—spirit that requires manifestation in time and matter that can do without space."

"We do not know what music is."

REVIEWS

INTRODUCTION TO PSYCHOLOGY FOR MEDICAL STUDENTS,

Hetherington, Miller & Neville, Heinemann, 1964. Pp. 212. *Price* 25s.

In the book's introduction is the statement that it was especially written for the medical student at the preclinical stage of his training, and to these people it will be an invaluable text. Although relatively short, the book covers a wealth of subjects, through perception, thought, learning and intelligence to motivation, conflict, emotion and personality traits. The book is completed by a consideration of the psychological aspects of the phases of life and ends with an excellent chapter on Interpersonal Relationships in Hospital.

Throughout, the book gives a balanced idea of the foundations of psychology —the basis of psychiatry and understanding the patient. The chapter on the placebo, for example, is particularly enlightening. It should be read before going on the wards, is an interesting and simple book, a worthwhile buy.

PAUL BOWDEN.

GERIATRIC INSTITUTIONAL MANAGEMENT.

Edited by: MORTON LEEDS and HERBERT SHORE. 1st Ed. Putnam's Sons, New York, 1964. *Price* 8$50.

The practice of geriatrics embraces several disciplines in addition to the study of disease in old people. These include aspects of social science, group therapy, in the occupational and social senses, and an understanding of psychological inter-relationships between different generations. Problems in geriatrics often present because the increasing restriction of independence and self-care due to the decline of physical and mental capacities. The burden falls at first on the family, then on the community and the State.

This volume of essays and articles by American writers in the social and medical fields deals with the implications of the problems of incapacity in old age. It aims at presenting an anlysis from several viewpoints of the resident of a Home himself—from the attitude of the potential applicant who requires to enter a residential home, to that of the doctor and nurse in attendance and also that of the administrative organisation sponsoring the Home.

It begins with a general review of the problems of ageing. This section is rather diffuse, and the facts tend to be submerged in a welter of words. Much useful information however, follows about social studies on " institutionalisation." The "levelling" of the newly arrived resident to the communal standard of the Home, and his interaction with the other residents and with the staff is discussed. The authors point out that the eventual settling in process should avoid engendering an institutional neurosis (a picture so commonly seen in large Homes in Britain and elsewhere). The value of extensive social case work is indicated in essays dealing with the relationships between the family and the parent, at the time the old person is entering a Home.

A number of interesting articles appear on group occupational therapy as a stimulus to the social environment. As well as the promotion of leisure activities, practical projects are described, such as Sheltered Workshops, in which there are regular working hours, and where the payment of even nominal wages emphasises to the individual his contribution to the social setting. The important part to be played by the residents themselves in the running of a Home is reiterated: for example, in the activities of an executive committee, the publication of a news-sheet, and participation in lectures and social groups. These useful chapters describe how a tactful approach by attendant staff can encourage reluctant and withdrawn residents to engage in activities which should increase self-assertion when that has been suppressed by the enforced communal living in a Home.

The medical section is of interest in demonstrating the organisation of a rehabilitation programme in some Homes. One article describes the successful participation by general medical interns and consultant staff of a nearby teaching hospital in the medical care and daily rehabilitation of the residents of an old age home. A Day Centre is described in another paper, but it is difficult to see how the British G.P. would be able to fit in with the model described, and the system would require modification in this country. The results of physiotherapeutic measures are stated in broad outline, and show that remobilisation and mental reactivation are possible in patients who might have been bed-ridden for years.

The administrator's viewpoint is put in several rather long chapters. The multidisciplinary nature of a Home is stressed—it should be orientated on medical and nursing and social lines, according to the need of different residents at different times. A useful grading is given of the type of chief administrator according to the diversity of duties and the size of the Home.

This book leaves the reader with the impression that the stage of entering a Home should begin a lease of new activity for an old person rather than a passive wait for his final day. The social background of the American scene differs from that in Britain, and financial considerations and voluntary homes figure more prominently than the Council Homes of our own society. Some of the ideas could be adapted for long stay units in geriatric departments although such patients are generally more disabled than those described in the book. Most of the articles are self contained, and some are better written than others. It succeeds in projecting the needs of the residents, and indicates the aims and principles which should guide attendant and administrative staffs of Old Folks Homes. It shows how elderly people, even when disabled, may still enjoy and contribute to society and this alone would make it a useful contribution to the community in the care of its geriatric population.

A. J. ROSIN

SPORT

CRICKET

It has been brought to our notice that the playing record of the 1st XI, as quoted in the last edition of the *Gazette* was incorrect, only two games having been lost and not three, as printed. Three games have now been lost, but two more have been won and another drawn to bring the present position to: Won 3, lost 3, drawn 4.

By now the team is beginning to perform nearer to its potential. The opening attack has more or less found its length, and in the first round of the cup against King's Knott, showed a return to last season's form by taking 5 wickets. The other five were taken by Davoodbhoy, who, as usual, bowled very well. The first four batsmen between them guided us to a comfortable victory. The catching in this match was good and in marked contrast to the previous week-end's game against the Strollers, whose eighth wicket partnership was allowed to add 100 runs to give them a two-wicket victory. It was calculated by a rather smug fielder, who caught his catch, but shall remain anonymous, that 12 chances were missed!

Against a very strong Stoics team we just held out for a draw, thanks not only to some sound defensive batting by Neville, but also to a somewhat cautious declaration by our opponents' skipper, for which, in retrospect, we are grateful.

Our disappointment that the match against the Reigate Pilgrims on their charming village ground was rained off on the previous Sunday was somewhat compensated for by a most enjoyable fixture against the Silhouettes, a team consisting largely of Guy's "Past", this Sunday. Guy's scored 222 for 3, of which McGregor scored a fine 70, and the Silhouettes, who included such names as Williams, Hambleton, Munro and Myall, were all out for 172, Appleby taking 6 wickets with his leg breaks.

Finally we are delighted to report that for the first time to our knowledge, the Hospital last Saturday turned out a 3rd XI, or to be more polite, a team which consisted of mostly 2nd XI standard players. They just lost to the London in what we gather was a most enjoyable game. We hope to be able to make this other team a more regular feature.

REPORTS AND RESULTS

GUY'S v. THE STOICS

At H.O.P. Wednesday, 12th May, 1965

Result: drawn

Deputising for Knott, Kendrick, in his first two overs for the 1st XI, took the wickets of Day, a Minor Counties and Club Cricket Conference player, and Hewitt, the other experienced opening bat. Davoodbhoy then took over and also dismissed more of the early batting, so that the Stoics were struggling at 80 for 5. However, our exaltation steadily diminished as Miller and Small punished the bowling in a century sixth-wicket partnership.

Guy's were set to score 214 to win in 123 minutes—a tall order which was never really attempted, since the steady fall of wickets against good bowling made even survival difficult. Credit must go to Neville, who played out the last half-an-hour to give us an undistinguished draw. Looking back on the game, the Stoics captain must have wished that he had made an earlier declaration, if only to give his bowlers time to take all 10 Guy's wickets!

Scores:

Stoics: 213 for 7 dec. (Miller, 78; Small, 59.) (Kendrick, 2—19; Davoodbhoy, 2—62.)

Guy's: 96 for 9. (Powell-Jackson, 32; Davoodbhoy, 17; McGregor, 17.)

GUY'S v. THE STROLLERS

At H.O.P. Saturday, 15th May, 1965

Result: lost by two wickets

Guy's won the toss, and elected to bat on the finest wicket seen at H.O.P. this season. McGregor soon spooned an easy catch to cover. This brought Cutler to the wicket, and he proceeded to bat beautifully. Appleby was the next to go, and Silk joined Cutler. After an uncertain start, Silk settled in, while Cutler, timing the ball perfectly, scored freely all round the wicket. He reached a faultless 50, made in an hour, and when he was eventually out he had made 70 out of 103. Silk and Powell-Jackson both played useful innings, enabling Guy's to declare at 181—6.

The Strollers, attempting to make the runs in 135 minutes, made a disastrous start, losing four wickets for 20 runs. Their seventh wicket fell with the score at 83, and from this point on, they were indebted to some very shabby Guy's fielding. By a mixture of luck, good hitting, and some appalling lapses in the field, their eighth wicket pair added 100 in the last hour. One more wicket was claimed just before the end, and they won by two wickets in the last over.

Only Davoodbhoy, who well deserved his six wickets, had any reason to look back with satisfaction on his performance in the field. This was a match Guy's should have won comfortably; the fielding will have to improve considerably if Guy's are to have any chance of winning the Hospitals' Cup this year.

Scores:

Guy's: 181—6 dec. (J. Cutler, 70; D. Silk, 35.)

Strollers: 186—8. (S. Davoodbhoy, 6—54.)

GUY'S v. KING'S COLLEGE HOSPITAL

At H.O.P. Wednesday 18th May, 1965

Result: Guy's won by eight wickets

King's won the toss, and on a soft wicket and with no great batting strength, somewhat surprisingly, elected to bat. Perhaps they knew that Knott, our opening bowler, was still operating. Nevertheless, Davoodbhoy, who shared the new ball with Beacham, always had the openers guessing, and soon bowled Clark. When Knott arrived, he took over from Beacham, who had bowled a good, though unlucky spell. In the first hour it seemed that no catch would go to hand. But the batsman's luck did not hold long, and some good catching, particularly by McGregor, had King's 55 for 6 at 1.15 when the rain came. For a long time one black cloud after another loomed up from the West so that it looked as if the morning session would be to no avail, and a replay would have to be arranged. Fortunately, after disagreement between the captains as to whether play was possible, the umpires agreed with the Guy's captain that it was—just! In very wet conditions Knott and Davoodbhoy, backed up again by good catching, disposed of the last five wickets for another 45 runs.

Now the sun shone at H.O.P., and during the fine evening it was pleasant to watch McGregor, Butchey, Cutler, and Powell-Jackson score 99 without any apparent trouble.

A good performance, and now with the London, who beat us in last year's final, knocked out by St. Mary's in the first round, Guy's must now be favourites.

Scores:

King's College Hospital: 97. (S. Davoodbhoy, 5—43; N. Knott, 5—38.)

Guy's: 99—2. (H. McGregor, 26; J. Butchey, 23; J. Cutler, 27 n.o.; J. Powell-Jackson, 20 n.o.)

GUY'S v. SILHOUETTES

At H.O.P. Sunday, 23rd May, 1965

Result: Guy's won by 50 runs

The many familiar faces of the opposing team graciously took the field after Guy's had won their third toss of the season. They were soon to realise that the outfield had been cut shorter than usual, and that the wicket was pleasantly hard. McGregor was quickly into his stride, and in just over an hour's batting scored 70 runs. Here again were the fluent cuts and drives, no longer the momentary lapses of concentration that have previously led him back to a premature pavilion shower. Silk joined him at 32, and these two took the score to 133, before Hambleton's yorker, the one that moves away in the air and straightens off the pitch, disposed of McGregor. Silk went on to complete his 50 in admirable fashion, and Guy's were able to declare at 222 at tea. The last over before tea deserves mention in that it was bowled by Mr. Richards, the eighth change, and in order to save both him and the batsmen further embarrassment, the Guy's innings was declared closed after the third ball.

When play resumed, the Silhouettes immediately rose to the challenge of scoring the runs at a rate of two per minute. Myall, having survived one or two close stumping decisions, scored a brisk 37 before being well caught. The run rate continued to be maintained by the later batsmen, most of whom were caught in an attempt to force the pace. It was good to see players deprived of either the opportunity to bat or to bowl put such an effort into their fielding. Rowlands, in particular, scoured the outfield and saved countless runs.

Finally, one was left with the memory of the player who, in a brave attempt to pick up the line of flight of the ball, executed two complete revolutions, one clockwise, one anti-clockwise, and one wondered what Nureyev might have thought of it all.

Scores:

Guy's: 222 for 3 dec. (McGregor, 70; Silk, 53; Powell-Jackson, 57 n.o.)

Silhouettes: 172 (Myall, 37; Henriques, 26; Munro, 25.) (Appleby, 6—102.)

ATHLETICS

Inter-hospitals relays and field events meeting
Aa Paddington track. 12th May, 1965

Result: Guy's won

This was the first ever U.H. relays meeting, and provided a most exciting afternoon's competition. Guy's finally won from St. Thomas's by three points, the result being in doubt until the final event of the afternoon. There were five relays, and a full programme of field events, the latter being decided on the aggregate distance of two competitions per team in each event.

Busiest man of the afternoon was D. Choat who ran the last quarter mile leg in three of the relays, coming through to win in two of these, and recording a time of 52.6 secs., which

was a personal best performance. J. Wheeler ran a fine 880 yds. in 2 min. 0 secs., and R. Holness and D. Briggs both ran sub-52 secs. for 440 yds. F. Nwator produced some determined running in his two furlongs, and ran a fiery last leg in the 4 x 110 yds. The best races of the afternoon were the 880, 220, 220, 440 and the 4 x 440, both of which Guy's won by about a yard following very well judged runs by all our runners.

In the field events R. Quinnell showed good form in the shot and javelin, and seemed fully recovered from the arm injury which kept him out of earlier matches, while Bailey, Bundred, Domaigne, Holness, Tong, and Bates all earned valuable points.

This win was a really fine team effort, and was achieved in spite of the fact that eight Guy's athletes were competing for the University on the same afternoon! If this excellent spirit is maintained, the team can look forward with some confidence to the U.H. Championships on July 3rd.

Results:

4 x 110 yds. (Bundred, Bates, Holness, Nwator). 2nd, 46.4.
4 x 110 yds. for throwers! (Quinnell, Bailey, Schofield, Bundred). 3rd, 49 secs.
220, 110, 110, 440 (Hong, Bundred, Nwator, Choat). 2nd, 1 min. 40.0.
880, 220, 220, 440 (Wheeler, Tong, Nwator, Choat). 1st, 3 min 40.9.
4 x 440 yds. (Wheeler, Briggs, Holness, Choat). 1st, 3 min. 34.1.
Shot. Quinnell, 38ft. 3in. Bailey 2nd.
Discus. Quinnell. Bailey 2nd.
Javelin. Quinnell, 134ft. Bundred 3rd.
High Jump. Tong. Domaigne 4th.
Long Jump. Domaigne. Holness 2nd.
Triple Jump. Bates, 39ft. 8in. Domaigne 1st.

In invitation events:

100 yds. F. Nwator 2nd., 10.3 secs.
120 yds. hurdles. J. Domaigne 1st, 16.4 secs.

Five Guy's athletes were in the London University team which narrowly lost to Paris Université Club in Paris on Sunday, May 9th. The best performances came from B. Hartley, who threw the Javelin 195ft.—his best ever, and I. Morgan, who ran 55.8 secs for 400 metres hurdles. The other members of the team were A. Winskill (110 and 400 m. hurdles), R. Morris (High Jump), and P. Peace (Shot and Discus).

On Wednesday, May 19th, at Motspur Park, four Guy's athletes formed a University "B" team for the 4 x 440 yds. in the U.L. match against the A.A.A. They finished in the highly respectable time of 3 min. 28 secs., I. Morgan producing a leg of 49.9 secs.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Senior Registrar in the V.D. Department,** with attendance on four sessions a week. Preference will be given to applicants holding a higher qualification. Appointment will date from 1st October, 1965, for one year. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, S.E.1, not later than **31st May, 1965.**

GUY'S HOSPITAL and SOUTH-EAST METROPOLITAN REGIONAL HOSPITAL BOARD

Applications are invited for the post of **Senior Registrar in Psychological Medicine to the Board of Governors of Guy's Hospital and the South-East Metropolitan Regional Hospital Board.** The appointment will be made jointly by the bodies concerned and will be for the period 1st August, 1965 to 30th September, 1968, with duties until 28th February, 1967, with the Bexley Group, and for the remainder of the appointment at Guy's Hospital. The post, which will be reviewed annually, is subject to the Terms and Conditions of Service of Hospital Medical and Dental Staff (England and Wales). Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, S.E.1, not later than **12th June, 1965.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **middle grade Registrar in Psychological Medicine,** with appointment from 1st October, 1965, for a period of one year in the first instance. Forms of application are available from, and should be lodged with, the Superintendent, Guy's Hospital, S.E.1, not later than **19th June, 1965.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Registrar in Thoracic Surgery** for a period of one year from 1st October, 1965. Forms of application are available from, and should be lodged with, the Superintendent, Guy's Hospital, S.E.1, not later than **19th June, 1965.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Registrar in E.N.T. Surgery,** for one year from 1st October, 1965. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, S.E.1, not later than **19th June, 1965.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Junior Registrar in Ophthalmology,** with appointment from 1st October, 1965, for a period of one year in the first instance. Forms of application are available from, and should be lodged with, the Superintendent, Guy's Hospital, S.E.1, not later than **19th June, 1965.**

GUY'S HOSPITAL, S.E.1.

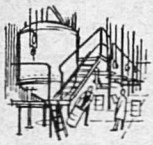
Applications are invited for the post of **Trainee Registrar (Registrar grade) in the Department of Diagnostic Radiology,** with appointment from 1st October, 1965, for one year in the first instance. Applicants should preferably hold a higher qualification in medicine or surgery, and there are facilities available to study for the D.M.R.D. Forms of application are available from, and should be lodged with, the Superintendent, Guy's Hospital, S.E.1, not later than **19th June, 1965.**

The Hormone House that Organon built

This is the idea that started the plan of the Hormone house that Organon built.

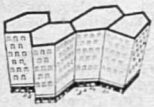
This is the researcher who had the ideas that started the plan of the house that Organon built.

This is the rat that was there at the start, as well as the cows, the sows and rabbits that enabled the researchers to probe the secrets of the hormones which built the house of Organon.



These are the workers who mixed the chemicals that joined up the molecules to make the bricks of the house that Organon built.

This is the doctor who found that the hormones helped his patients and prescribed the products of the house that Organon built.



The Hormone House

Organon

ORGANON LABORATORIES LIMITED
CROWN HOUSE LONDON ROAD MORDEN SURREY ENGLAND

GUY'S-MAUDSLEY NEUROSURGICAL UNIT

Applications are invited for two posts of **Senior House Officer** (resident), one for the six months commencing 1st August, 1965, and the other for six months commencing 1st September, 1965. The Unit, which is housed in the Maudsley Hospital, serves both Guy's Hospital and the Bethlem Royal Hospital and the Maudsley Hospital. Applications should be made by the **5th June, 1965,** to L. H. W. Paine, House Governor and Secretary, The Maudsley Hospital, Denmark Hill, S.E.5.

GUY'S HOSPITAL MEDICAL SCHOOL, S.E.1.

Applications are invited for the **Astley Cooper Studentship** tenable at Guy's Hospital Medical School. The Student, who is the Astley Cooper Assistant to the Curator of the Gordon Museum, will be elected for a period of three years, the salary being approximately £140 per annum. Applications should be made on a form obtainable from the Dean, Guy's Hospital Medical School, S.E.1.

HOUSE APPOINTMENTS

GUY'S HOSPITAL

June 1st, 1965

Assistant House Surgeons

To:
Mr. Lawrie — Miss J. A. Chown
Appointed for 6 months, the first 3 as A.H.S.

Mr. Glover — Mr. M. B. Barnett
Appointed for 6 months, the first 3 as A.H.S.

Mr. Brain — Mr. B. H. Hicks
Appointed for 6 months, the first 3 as A.H.S.

Mr. Beard — Miss J. Pearse
Appointed for 6 months, the first 3 as A.H.S.

Assistant House Physicians

To:
Dr. Mann, Dr. Scott and Dr. Bishop — Mr. C. G. C. Gaches
Appointed for 6 months, the first 3 as A.H.P.

Dr. Hardwick, Dr. Trounce and Dr. Deuchar — Mr. P. D. Davies
Appointed for 6 months, the first 3 as A.H.P.

Dr. Baker, Dr. Houston and Dr. Grimble — Mr. P. C. Smith
3 *months*

Dr. Kauntze and Dr. Joiner — Mr. A. M. Roberts
Appointed for 6 months, the first 3 as A.H.P.

Professor Butterfield and Dr. MacLean — Miss C. J. S. Lawrie
Appointed for 6 months, the first 3 as A.H.P.

Assistant House Surgeon to the Surgical Unit

Mr. M. L. Wastie
6 *months*

Casualty Officers

Mr. I. A. Baker
Mr. A. L. W. F. Eddleston
Mr. G. Hambleton
Mr. T. M. Jenkinson
Mr. M. W. J. Older
Mr. R. A. Y. Pietroni
3 *months*

House Surgeons

To:
Mr. Eckhoff — Mr. H. D. Tunstall-Pedoe
6 *months*

Professor Atkins — Mr. J. R. W. Keates
3 *months*

Mr. Wass — Miss C. G. E. Gladstone
6 *months*

Mr. Blackburn — Mr. T. J. B. Harris
3 *months*

House Physicians

To:
Dr. Mann, Dr. Scott and Dr. Bishop — Mr. R. Gilkes
6 *months*

Dr. Hardwick, Dr. Trounce and Dr. Deuchar — Mr. A. J. Knell
6 *months*

Dr. Baker, Dr. Houston and Dr. Grimble — Mr. F. D. Higgs
3 *months*

Dr. Kauntze and Dr. Joiner — Mr. C. P. W. Warren
3 *months*

Professor Butterfield and Dr. MacLean — Mr. T. C. Davis
6 *months*

Resident Obstetricians

1.3.65—31. 8.65 — Mr. J. B. M. Shepherd
1.6.65—30.11.65 — Appointment not yet made

Gynaecological House Surgeon

Mr. P. J. Rowe
3 *months*

Throat and Ear House Surgeons

Mr. T. E. J. Healy
3 *months*

Mr. J. M. I. Iveson
6 *months*

Orthopaedic House Surgeons

Mr. G. F. Falconer
6 *months*

Mr. I. C. M. MacLennan
6 *months*

Dermatological House Physician

Mr. R. John Parker
6 *months* from 1.8.65

Neurological House Physician

Mr. I. Vadasz
3 *months*

Genito-Urinary House Surgeon

Mr. P. A. Kitchener
6 *months*

House Surgeons to the Thoracic Unit

Mr. S. Nundy (S.H.O.)
3 *months*

Mr. J. G. Cochrane
6 *months*

Children's House Physicians

Mr. C. J. Atkins
3 *months*

Miss S. A. Marshall
6 *months*

House Physicians in Clinical Pathology

Mr. P. Sender
3 *months*

Mr. M. D. Jones
6 *months*

House Physician to Dr. Bishop, Dr. Wayte, and Mr. McArthur

Mr. R. A. Sturge
3 *months*

House Physicians in the Department of Psychological Medicine

1.4.65—30. 9.65
To:
Dr. Stafford Clark — Miss M. Restell
1.4.65—30.9.65
Dr. Fleminger — Mr R. H. S. Mindham

R.M.Os. in Nuffield House

1.1.65—30. 6.65 — Mr. I. M. Boyd
1.3.65 31. 8.65 — Mr. J. D. Jessop
1.7.65—31.12.65 — Mr. C. S. Good

Resident Anaesthetists

1.3.65—31. 8.65 — Miss D. Hart (S.H.O.)
1.3.65—31. 8.65 — Mr. R. K. R. Innes
1.6.65—30.11.65 — Mr. M. J. Wright (S.H.O.)
1.6.65—30.11.65 — Mr. D. E. Nancekievill

BECKENHAM HOSPITAL

House Physician: Mr. A. H. Mowbray
House Surgeon: Mr. S. Bhanji

LEWISHAM HOSPITAL

House Physician to Dr. Roberts:
Mr. P. Garcia-Webb-Sharp
House Surgeon to Mr. Glyn-Evans
Mr. A. Stevens

NEW CROSS HOSPITAL

House Physician: Mr. L. Levinsky
S.H.O. in Medicine and Geriatrics:
Mr. G. D. Nicholson

ORPINGTON HOSPITAL

House Surgeon with Ophthalmology:
Readvertised
House Surgeon with E.N.T.:
Mr. D. W. Bainbridge
House Surgeon with Orthopaedics:
Readvertised

PEMBURY HOSPITAL

House Surgeons:
Mr. R. J. Siggers
1 vacancy readvertised
House Physician: Mr. T. B. W. Johnson

QUEEN MARY'S HOSPITAL, SIDCUP

House Physician: Mr. L. D. Edwards (1.7.65)

ST. JOHN'S HOSPITAL, LEWISHAM

House Surgeon: Mr. A. J. Medhurst

ST. OLAVE'S HOSPITAL

House Physicians:
Mr. M. G. Barley
1 vacancy readvertised

J. B. BLAIKLEY,
Superintendent

May 21st, 1965.

PASS LISTS

ROYAL COLLEGE OF PHYSICIANS OF LONDON

At a Comitia of the College on April 29th the following were elected to the fellowship:

Sir Russell Brock — M. A. Partridge
S. H. Llewellyn-Smith — C. L. Joiner
J. J. Fleminger — K. O. Rawlings

At a Comitia of the College on May 5th the following were elected to the membership:

I. D. Green — P. W. R. Harris

ROYAL COLEGE OF PHYSICIANS OF EDINBURGH

At a meeting of the college on May 4th, Dr. J. P. Vaughan was elected to the membership.

ROYAL COLLEGE OF SURGEONS OF ENGLAND

L.D.S.

Dental Prosthetics and Properties of Dental Materials

P. T. Blenkinsopp — N. J. B. Head
A. A. Forbes — J. G. Kingsbury
D. A. Graham — N. A. Tilling
R. M. Watson

NURSING NEWS

Entered

Sister B. Woolley to Victoria.

Left

Sister S. Rouy from York Clinic.

PERSONAL

Lewes, Sussex. Assistant required with eventual view to Associate Partnership if desired in large group practice. We are looking for a young, preferably Guy's-trained, graduate with House Surgeon experience if possible. In return for a high standard of work we can offer a congenial working atmosphere in beautifully equipped Surgery. Interesting, varied week with every type of work available in excess, including facilities to learn I.V. techniques, and a local hospital. Full-time Oral Hygienist and large, well-equipped Laboratory with specialist Chrome and Porcelain techniques.

For further details of this excellent opportunity to join a progressive, modern group practice, please write giving full details to Box No. 10.

CHANGES OF ADDRESS

Dr. D. C. Deuchar, to Tile House, Bickley Park Road, Bickley, Bromley, Kent. Telephone No. Imperial 2113.

Malcolm and Delia Forsythe, to 1a, Sandy Road, Norton, Stourbridge, Worcs. Telephone No. Stourbridge 3107.

ENGAGEMENT

BOWDEN—WEBB. The engagement is announced between Paul, son of Mr. and Mrs. S. K. Bowden, of Trentham, Stoke on Trent, Staffs., and Ann Dames, eldest daughter of Mr. and Mrs. Henry Webb, of Barrow-in-Furness, Lancs.

MARRIAGES

STEYN—MEHTA.—On March 9th, 1965, at Auckland, New Zealand, Dr. M. D. Steyn, M.B., B.S., to Miss Barbara S. Mehta.

GUY'S HOSPITAL GAZETTE

FORTNIGHTLY ONE SHILLING VOLUME 79 NUMBER 2006

12 JUNE 1965

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EDITORS P. BOWDEN AND A. E. RAYNES

SPORTS CORRESPONDENT A. PROCTER

GUY'S HOSPITAL, LONDON

PASSIM

Gazette Subscriptions

We announce, with regret, that the annual subscription for the *Gazette* will be increased to two guineas from 1st July, 1965.

In ninety years the cost of the *Gazette* has increased only three-fold from its 1872 price of twopence per copy. It remains the oldest and most frequently published hospital journal in the world. In the past, when profits were made, they were passed on for the use of the various activities of the Club's Union, but in recent years, in spite of an increase in circulation, the *Gazette* has had an adverse financial balance. Increasing costs of production and, most recently of all, increase in postage rates have made the increase in subscription rates inevitable if the *Gazette* is to remain solvent. We hope that our readers will continue to give us their support so that the Editors may be able to continue in their efforts to produce a better magazine without having to economise further on the number of editorial pages and illustrations.

Voices

The spoken word has the advantage over its written colleagues in that it can benefit from the oratorial qualities of the speaker. Who could forget the enthusiastic platitudes of Alvar Liddell as he brought us more news of fresh disasters, they, he assured us, were having a great and patriotic time dying. Alan Keith's voice is a continuation of Your Hundred Best Tunes and after each he pauses awhile respectfully, before mouthing, with soporific sonancy, the plot of the next piece. He is apologetic that Tchaikovski is dead, pays homage to his name and, oozing emotion in his voice, fades out to become music.

One would expect that Dylan Thomas would have imparted some portion of his illustrious and alcoholic Welsh past into the recitation of his poetry but his voice was strong and very English and because his verse is primarily concerned with the manipulation of words, the result is an onomatopoetic patter of perfection. Thus words have, besides their intrinsic meaning, another interpretation based on the mouths from which they are sophisticated and spoken. Ertha Kitt manages to convey (like the whispering of Burke's Law) something that supercedes language itself.

The Usual Story

A recent poster on the tree outside Smith's informed us that "debating is a dirty word at Guy's". At the risk of a lapse in our language, this itself might be debated. These posters tell of the sad fate of the Debating Society. Its struggle for survival in an atmosphere of student disinterest could only end in a spate of non-functional advertising. The Debating Society now joins the Quodlibet which faded away without even achieving the dubious status of a "dirty" word.

Organised student communication at Guy's is at a low ebb, but it would be misguided to assume that this necessarily arises out of apathy. The popularity of the different societies reflects the demands or non-demands of the students. If the demand does not exist then it is wrong to attempt to supply something on the assumption that it does. This only creates an artificial situation in which the student becomes irritated by the frequent harangues of the organizers who are numbed by their own enthusiasm. Their disillusionment may be brightened by looking at the student body through the wooden bars in the Cafeteria.

Gentle stirrings around the hospital indicate that the magazine *Pulse* is about to make one of its rare appearances. The success of this magazine, under its new direction, will be determined only by Guy's students. If they have anything to say at all and need a platform then it will survive, otherwise the editors may rest assured that their task is unnecessary rather than unappreciated.

Dr. C. A. Clarke, consultant physician at the Liverpool Royal Infirmary, Broadgreen Hospital, and at the Liverpool Radium Institute, and director of the Nuffield unit of medical genetics, has been appointed to the Chair of Medicine at the University of Liverpool. He succeeds Lord Cohen of Birkenhead on September 30th, and we offer him our sincere congratulations.

"Fire caused a small explosion in a ground floor laboratory at Guy's Hospital Medical School, London," as described by the *Daily Mail,* but it was not enough for the *Daily Express,* " **School Blast.** A small explosion rocked Guy's Hospital Medical School, London, yesterday after wiring caught fire in a laboratory. No one was hurt."

GUY'S DIARY

JUNE.

Exhibition.		*Conjoined Twins.*
14th M.	1.00	Mr. CRABBE. Clinical Lecture. *Malignant Tumours of Bone.*
15th T.	1.00	Dr. MANN. Clinical Lecture. *Diarrhoea.*
16th W.	2.15	Radiotherapy Tumour Conference. *Carcinoma of the Bronchus.*
17th Th.	5.00	Mr. MURRAY FALCONER. Neurosurgical Round.
18th F.	1.00	Professor BUTTERFIELD. Clinical Lecture.
21st M.	1.00	Dr. BAKER. " *Arrythmias with Myocardial Infarction.*"
22nd. T.	1.00	Dr. BISHOP. " *Intersex.*"
24th Th.	1.00	Mr. LAWRIE. Clinical Lecture. " *Oral Cancer.*"
25th F.	1.00	Dr. TROUNCE. " *E.Coli Septicaemia.*"

CONSUMER MEDICINE

DR. ABRAHAM MARCUS

The consumer of goods wants to feel that he can exercise choice intelligently between grades of quality. The consumer of medical services wants to be relieved of the obligation to choose in this way. This is the essential difference between the two kinds of consumer simply because medical services, more than any others, involve health and well-being.

The consumer movement as we know it resulted from two great post-war developments, increased purchasing power and technological advance. We can afford to buy more and we have higher aspirations that have been encouraged by greater leisure and the spread of new ideas of living and the enjoyment of living by press, popular magazines, radio and television. And we are confronted by an ever-widening range of goods sold competitively by high-pressure advertising, using new materials, manufactured by new techniques and promising new standards of performance. It is no longer possible to judge and appraise out of the common background of life. One must have some expert guidance or one is lost.

Goods rather than services continue to be the concern of the consumer movement because it is far easier to set standards of appraisal when there is a definite end-product that one can see and feel and measure. Only through measurements can one make valid comparisons and quality, in the main, becomes the summation of values based on various quantitative measurements. One cannot measure a service in this sense and it has to be appraised by analysis of its parts, how they interact and how they meet the aims for which the service exists and, indeed, how these aims fit the situation for which they were set. This is operational research, an activity which has not yet been taken up by the consumer movement.

Our whole approach to the question of standards must be different in a service and, inevitably, more subjective. The standard we receive is often a tacit compromise. Those providing the service have one set of limitations, those using it have another set of limitations. The acceptable standard is somewhere between the two. The offered standard, the standard we usually accept, is nearly always inferior. Our attitude towards it depends on the importance of the service and the amount of information we have about its defects. But there is also an optimum level of performance of which the public may be only vaguely aware.

Quality in a service can be defined, very roughly, as the extent to which possibilities of giving satisfaction are realised. Difficulties are likely to arise in deciding what the possibilities are and what people mean by satisfaction. This lack of precision, inherent in the situation, leads to divergences between the offered level of quality, the acceptable level and the optimum level; it is often exploited, usually unconsciously, by those who provide services. Ideally, all three levels should coincide.

This article is based on a lecture, originally given at Goldsmith College, in the series "Towards Better Medical Care."

The situation is not a simple one and it is even more complex in dealing with medical services, the most important of all to our health and well-being, in which the level of quality offered to us should be the highest. If two medical services are available we are not content to accept the cheaper and inferior, if we could recognise it, as we might accept the cheaper and inferior of two refrigerators if we could not afford the other or as we might accept the minor discomforts of travelling second-class. In these latter cases we are prepared to make the choice dictated by our pockets. But in medicine there can be no choice between bad and good, not even between better and best. We do not want to be forced into accepting a choice that involves grades of quality.

By providing a free Health Service we no longer compel choice of medical services by price and we accept in a formal way the obligation to promote the highest standards though we do not always achieve them—far less often, probably, than we fondly imagine.

The objective of the consumer of medical services is to secure the highest standard of care for himself, his family and the community. There are many difficulties. The ordinary person cannot criticise medical services with any insight. To him the main indicator of the quality of service is the humanity of the doctor. If one is treated decently and affably one tends to assume that all is well. But humanity can be the veneer of bad doctoring as much as the foundation of good doctoring. One must confess, though, that it is extremely difficult to measure quality in medical care. It is doubtful if one can measure it at all, in the strict sense, and it is certain that one cannot measure it directly—after all, people often get well in spite of the doctor.

Obviously, if the consumer is to exert pressure for improved standards he has to be well informed about our medical services and about the potentialities inherent in medicine that are not being realised or are being realised inadequately. Unfortunately, at present there is no agency to perform this duty of educating the public as consumers of medical services although the need of the public to express views as consumers has been given some effect by the formation in recent years of a number of organisations—Mothers' Care for Children in Hospital, Association for Improvement in the Maternity Services, Patients' Association. Worthy and well-meaning as they are, these organisations do not seem to be working along the best lines. They don't appear, usually, to seek the right kind of expert advice, often they have a narrow class bias and much of the time they antagonise, unnecessarily, those whom they must convince if changes are to be made.

Even so, the consumer movement has entered if only in a tentative way. So far it has made little impact because the consumer does not know what questions to ask nor how and where to get the basis of information on which to criticise medical services intelligently and use them more effectively.

By consumer medicine I mean the kind of information necessary to the consumer and the activities he must engage in to secure medical services of the highest standard. He needs information that will help him to appraise a medical service when he is using it; information that helps him to appraise the general aims and purposes of a service so that

he can discuss it effectively and understand its short-comings; information that helps him to influence the direction in which medical services grow and develop by helping him understand the possibilities inherent in medical advances and the needs arising out of social change.

In trying to appraise a service when one is using it one is attempting a consideration of quality. One cannot really measure the quality of medical care, as I have said, because one cannot make physical tests of comparison as one can to material objects. A human being is not a washing machine and a medical procedure is not a manufacturing process. The fact that the patient lives or dies is, in itself, not a measure of quality. Some people get well in spite of all that is *not* done, others die despite all that *is* done.

What one can say about quality in medicine is that in certain circumstances there are certain things that we know ought to be done and one can find out whether they are done or not. The quality of the doctor becomes all the more important as medicine progresses. The more things a good doctor can do for his patient the more there are that a poor doctor can fail to do or do inadequately. The study of quality, therefore, is largely a search for omissions.

Much of our most interesting information about quality deals with the maternity services. The study of perinatal mortality—deaths of babies within one week of birth—which covered the histories of the pregnancies and labours of thousands of women shows many glaring omissions. The cardinal rules of good ante-natal care were being flouted by many doctors, especially general practitioners. There are a number of things that we know ought to be done for the pregnant woman. Blood tests must be done, blood pressure and weight must be measured at each visit, and urine examined. These procedures are essential to anticipate risks such as haemorrhage and pregnancy toxaemia. There is no excuse for not doing them. Yet, of women looked after by general practitioners, 60 per cent were not tested for haemoglobin, the index of anaemia; of those looked after by general practitioner and midwife 67.9 per cent were not tested and of those looked after by the midwife alone 77.5 per cent were not tested. In local authority clinics tests were omitted in 35.2 per cent. General practitioners did not read the blood pressure at every visit in 17.8 per cent of women and 12 per cent of women looked after in general practice were not tested for Rhesus group.

Since 1928, confidential enquiries into maternal deaths have been carried out every few years. Records of all women dying in pregnancy and childbirth are studied and an effort is made to discover some error of omission or commission—an avoidable factor—that may have contributed to death. One finds, for example, that women with severe toxaemia were being treated at home too long. Cases of hospital confinement were badly selected. There was confusion of responsibility between general practitioner, midwife, clinic and hospital. In many cases of haemorrhage, haemoglobin had not been tested and the possibility of anaemia had gone unrecognised. One should add that many women had contributed to their own deaths by refusing to take the advice of the doctor.

There are other indications of the quality of general practice—the frequency with which the general practitioner uses diagnostic facilities at

the hospital, the condition of his premises, the amount of ancillary help employed, the use of an appointment system. But many more studies are needed. Hospitals, too, are open to criticism but again, too few studies have been done. There is a rooted objection in British medicine to accepting the idea of quality studies as a means of eliminating faults and improving standards, in spite of the fact that maintenance of standards by every means should be one of the marks of a profession. This is all the more serious in view of the large measure of self-government enjoyed by the medical profession and the implied responsibility for scrutinising standards in the public interest.

When we come to appraise the aims and purposes of a medical service we are in a more general field in which more and better information is also needed. There are many points of controversy in medical affairs, some of which are aired in the press though not often in a balanced way—humanity in hospitals, should mothers go into hospital with their young children? our school health service, the new hospitals and, just now, the future of general practice. Often these controversies are given a particular bias by well-meaning people, and as a result the issues are obscured and judgment is clouded. The question of humanity in hospitals is important but too often this discussion has been carried on as if it were one of middle class standards of politeness and good manners only, especially in the case of maternity hospitals. It is forgotten that the most important events in pregnancy and childbirth still take place in the pelvis and not in the mind. However modern and reassuring and exhilarating it may be to have one's baby in the presence of one's husband, one would be far happier if one were certain that the mother had been examined regularly in pregnancy, that her haemoglobin had been measured, her blood Rhesus grouped, her blood pressure and weight taken at every visit and her urine tested, and that the delivery was being supervised by a competent and experienced senior doctor instead of a young houseman, and that the most modern means of resuscitation were available in case the baby needed them. I am not decrying the campaign for more humanity in hospitals; I am just attempting to inject a sense of proportion. Humanity in medicine begins with the determination to provide one's patients with the best service at the highest standards. It is a question of skill and technical competence. But of course it does not end there.

The controversy about mothers going into hospital with their children is also worth discussing. It has been said, with some authority, that a child may suffer some psychological harm if separated from its mother to enter hospital. Certainly the child will be unhappy and one would want to dispel the unhappiness whether the effect were likely to be permanent or not. But the anxiety to prevent any ill-effect has grown into a middle class crusade led by newspapers and magazines to whom the modern cult of child psychology is an important part of "with-it" journalism. Yet there are other points of view that have been overlooked.

It is easy enough for the middle class mother to go into hospital with her child; grannies and aunts may be able to help in looking after her small family. But what about the more heavily burdened working class mother who may have a larger family to look after? We ignore

also the different attitudes and customs of people. The middle class husband sees himself as a partner in the family chores, unlike the working class husband, and the working class wife lacks the brash assertiveness of the more affluent mother who "knows her rights". I don't think the scheme is quite so satisfactory in working class areas.

But the main point is that other ways of dealing with the problem of children in hospital are overlooked. In some parts of the country there have been special facilities for home nursing to help keep the ill child at home. One London teaching hospital has been running a home care service for children. Doctors and nurses from the hospital go out to the homes at the request of the general practitioner and make regular visits daily or twice daily to the sick child who very often might otherwise have been admitted to hospital. This idea of bringing the hospital to the child might be explored further. Even in certain surgical cases there is the possibility as one doctor has shown of abolishing the stay in hospital by admitting the child in the morning and sending him home in the afternoon when the operation is over and he has recovered from the anaesthetic.

These developments, lacking perhaps the dubious sanction of some special psychological theory but based on common sense and a practical assessment of the possibilities of modern medicine, receive little or no publicity and people are not aware of what can be and is being done if only on a very limited scale.

On general practice, too, the public is not well enough informed to understand the new trends that ought to be encouraged if we are to have a modern system of community care. We are in the midst of a bitter controversy in which, unfortunately, the public interest may be affected because neither side, particularly the doctors, is likely to give it full consideration. The Ministry of Health has the duty of safeguarding the public welfare; the same duty is implicit in the traditional ethics of the medical profession. Yet the Ministry may be forced to compromise the public interest by expediency while the doctors, overwhelmed by reaction, are moving further away from the community into a self-centred isolation. The simple question is this: Does the doctor exist for the patient or the patient for the doctor? Changes are necessary and we know, substantially, what these changes ought to be. Government, though, is slow to offer possibilities of change partly for financial reasons, partly out of a reluctance to risk the charge of imposing solutions on the doctors. The doctors, on their side, cling to the illusion of private enterprise, a nostalgic link with the past when the doctor, as they fondly imagine, was better off and better respected, an authoritarian father-figure truly embodying the professions' pride in its omniscience, its aloofness and its favoured position as a self-governing autocracy within society.

Information is also needed to help us influence the direction of growth and change in medical services. This is not always easy but from time to time certain possibilities arise out of medical advances. In recent years it has become increasingly likely that we are on the threshold of a revolution in preventive medicine through the routine application of simple diagnostic tests that can reveal the presence of disease in its very early stages long before symptoms would be experienced. At present

this is practicable only in a limited number of conditions. By our failure to apply these measures opportunities are being neglected to save or prolong life and to limit disability. The outstanding example of cancer of cervix in women is well-known and some progress is being made, mainly as a result of public agitation, in setting up a system of routine screening for women exposed to the risk.

The new preventive medicine is more than the application of innovations in diagnostic technique. It demands a different order of obligation to the patient, a different concept of the practice of medicine. Through the detection of disease in its earliest stages one seeks to preserve health rather than restore it after disease is more fully developed. Treatment *is* prevention when applied early enough; this is the medicine of health, not of disease. It implies true continuity of care for the doctor is now concerned with his patient when he is well by attempting to anticipate the possibility of disease through his knowledge of epidemiology and his understanding of the patient's life, environment and habits. One is adding a new dimension to medical practice.

Changes of this sort do not arise only out of advances in medicine and medical techniques. The emergence of new patterns of living in the community, higher expectations and aspirations also affect the ways in which medicine is practised by influencing its organisations and institutions although these are slow to respond, as current events show only too well. What we are really talking about once we move to a social context is medical care not medicine. Medical care is a social concept. Medicine, what we have always talked about in the past, is the technical and professional element isolated from this concept. For our purpose it can have only a restricted meaning.

Information is one thing, action is another. What should an organisation of medical consumers do? In short, having found out what questions to ask, it should ask them. But one cannot pretend that it would be easy to take effective action. Authority, governmental and professional, is not going to be co-operative at first. One must lay the foundations very carefully. One must not adopt a legalistic approach and "fight for the rights of patients". If one does one will be involved in a series of contests—patients versus government, patients versus doctors, patients versus research scientists, versus hospitals, versus the drug industry. I am not suggesting that rights are not to be protected or extended, but if this is to be the sole or main activity the movement ends up as a small, strident protest group rather than as a genuine consumer organisation appraising and improving services. The most important right—to the best possible standard of medical care—depends on creating a climate of opinion particularly within the Health Service that accepts the constant striving after improvement as a matter of everyday policy.

The policy of a movement of medical consumers must be the promotion of improvement in our medical services and in furthering this policy it must seek the co-operation of doctors and official bodies. Doctors must be involved in one's organisation from the beginning. Most of them will resent one's existence but there are many enlightened doctors who realise that by involving the patient in medical care it can be made more effective. One needs doctors, too, to provide expert advice.

The organisation will have to carry out its own investigations. Information that is not already available must be sought out by appropriate methods either through research groups in medical schools and universities or through one's own research department. Simple surveys, well-designed and carefully done, can help to reveal weaknesses and inadequacies in our medical services and point out the need for more detailed study by operational research techniques. This is analogous, to some extent, to what consumers' organisations dealing with goods already do. The analogy must not be carried too far even though one is also looking for the "best buy" in medical care on which to spend the community's money, that is, the most effective way to use our resources in securing a particular objective of medical care.

Consumer medicine can be most effective at local level. There is great scope for collecting information about local medical services and for direct observation of services in action—hospitals, mental health, geriatrics, school health, midwifery. Consumers can get together with their general practitioners to discuss problems and with consultants and hospital administrators. It may be difficult at first to arrange such meetings. Once patients have more information out of which to appreciate possibilities and can show that their purpose is constructive, it should become easier. Doctors would have to learn that a strong, well-informed consumers' movement in medicine is also for their benefit. The creation of mutual confidence between doctors and patients is a very good basis for action.

The central organisation would collect and disseminate information and advise local groups. People must be helped to understand what is happening in their own Health Service and be encouraged to express their opinions. The important thing is to be able to ask questions and to ask them. The central organisation would also make the best use of the various publicity media—press, television, radio. Television is an ideal medium for helping the public to understand consumer medicine.

One hopes that in a short time a medical consumers' organisation would gain the recognition to entitle it to nominate representatives to various committees that play a part in running the Health Service. There is a pseudo-democratic structure in the Service.

One may object that such apparently mild methods are unlikely to lead to much progress. On the other hand there is some evidence to support the view that in general practice at least the more knowledgeable the patients and the higher the standards they expect, the more competent are the doctors and the higher the standard of care they offer. Comparisons of doctors and practices in working class and middle class areas support these impressions. Some progress would be made if middle class standards, divested, of course, of middle class prejudices, were imposed on medical practice throughout Britain.

There are things the individual can do in his own interest simply by asking the right questions. Whenever there are easily recognised indicators of standards he can look for them. The woman receiving antenatal care can be told exactly what she is entitled to expect. She will know if her blood is not sampled, if she is not weighed at every visit, if her blood pressure is not taken or her urine tested. If there are

omissions one can know, and why should one not say so. "Doctor, why haven't you taken my blood pressure?" It should be a sobering thought to all those anonymous G.Ps. and other doctors who conduct ante-natal care inadequately that, collectively at any rate, they stand condemned of negligence. The woman who gets such poor care may lose her baby or suffer far more than she ought.

Still on the subject of general practice, why shouldn't the patient say, "Doctor, why don't you have an appointment system, so that we don't have to wait so long?" "Doctor, why don't you have a secretary, it would be so much easier for all of us?" and so on. No doubt it takes courage to ask such questions but if one is speaking as an informed person and as a member of a group it becomes a little easier. Imagine the effect on a general practitioner if only 5 per cent of his patients put these questions. If the patient can be accused of overuse of the doctor's services many doctors in general practice and in hospital can be accused of under use of medical knowledge and organisation.

One is proposing a revolution but one wants to be polite about it and one wants it to take place as quietly as possible. One can mention many things worth pressing for—better education of general practitioners, more and better information about the Health Service so that we know where we are, a system of quality control in hospitals and in general practice, group practice as the basic system of family care, more planned experiments to find out the best way to use our resources in the interest of the patient.

The main thing is to introduce a more dynamic approach both in Government and profession to the whole field of medical care so that instead of a good second-rate Health Service we can in the not too distant future realise the promise that has lain dormant for so long so that the patient when he goes for medical care knows that everything has been done to achieve the highest quality. It is *our* Health Service and we are entitled not only to use it passively but to help in improving it as active participants.

R. B. FAWKES, D.S.O., M.C., M.R.C.P.

Many Guy's men of the 1914-18 vintage will be sad to hear of the death of Dr. R. B. Fawkes, which occurred suddenly on 24th April, 1965. Always known as Guido at Guy's, he entered the Medical School after a distinguished career in the Northamptonshire Regiment as a combatant officer, in which he was awarded the D.S.O. and M.C.

Dr. Fawkes was rather older and more mature than most of his fellow students at Guy's, by whom he was well liked and respected. On qualifying, he did the normal round of house-appointments, and in 1925 he took the M.R.C.P. Lond. In 1926 he went to Cromer in general practice where he soon became known as a first-class clinician. When the National Health Service was established in July, 1945, Fawkes gave up his general practice and was appointed as a consultant in medicine, under the East Anglican Regional Hospital Board. For many years he played an important part in local government and was Chairman of the Urban District Council.

Baby Jane

J. V. COLLINS

This is a short account of a new-born infant who was found by a Southwark Borough Council refuse collector in the rubbish chute of a tenement building near the Blackfriars Road.

At 8.30 a.m. on Thursday, 13th May, 1965, the refuse collector began the weekly clearance of the chute and had already removed one load from the bunker at the bottom when he heard cries coming from within the chute. He thought these were coming from some kittens which someone had placed there, apparently a not uncommon occurrence. He continued to pull the rubbish from the chute with a rake and then more slowly with his hands. When he had removed a quantity, which he estimated later would have reached to first floor level, an infant rolled from the chute into the bunker. The umbilical cord was wound round the infant's neck and the placenta was still attached. He and his workmates wrapped the infant in a pocket handkerchief and called the Police.

The Police brought the infant to Guy's Casualty Department at 8.45 a.m., where she was seen by a Casualty Officer, who cut the cord and arranged for her immediate admission to Diplock Ward.

Medical History

At the time of admission the infant was covered with ashes, leaves and other debris and smelt strongly of her recent surroundings. She did not appear to be seriously injured and responded normally. Physical examination revealed a rectal temperature of 92.4°F. and pulse rate 140/min., regular and of good volume. The systolic blood pressure was 100 mm. Hg. and her weight was 5 lbs. 2 ozs. Her skin colour was pink except for some cyanosis of the extremities and moderate jaundice.

There were areas of sclerema and superficial abrasions over the dorsal spine and buttocks, and there were multiple bruises on the

face and anterior body wall, with two deep ulcers on the left side of the back of the head. There was also mucopurulent exudate in the eyes. No abnormalities were detected in the cardiovascular, respiratory, alimentary or nervous systems and there were no injuries to the skeletal or muscular structures—later confirmed by whole body radiographs.

The blood count and electrolytes were normal. The serum bilirubin was raised to 6 mgm/100 ml and had risen to 10 mgm/100 ml 48 hours later. The results of cultures made from swabs taken from the various abrasions are shown in Table 1. The placenta was circular and intact. It was $5\frac{1}{2}$ inches in diameter with one umbilical cord centrally inserted. Part of the membranes were missing.

TABLE I.

Site:	*Organisms:*
Umbilicus	B. Coli, Strep Faecalis, β Haemolytic Strep.
Throat	B. Coli. Para colon.
Eye	Staph. Aureus
Vagina	Strep Faecalis.
Skin Lesions	B. Coli. Strep Faecalis.
Blood Culture	B. Coli. Ps. Pyocyanea.
Urine	B. Coli.

Management and Progress

Tetanus toxoid was given and oxytetracycline and penicillin were given to prevent infection. The eyes were treated with Chloramphenicol drops and the discharge had cleared after 48 hours. The jaundice had faded by the fourth day after admission and the skin lesions and umbilicus were healing well except for the deep ulcers on the scalp, which continued to discharge for a further 48 hours. On the fifth day after admission there were signs of a urinary tract infection but as the organisms responsible were reported sensitive to the antibiotics already given no other treatment was prescribed. Feeding was begun on the day of admission with 5% Dextrose and was changed to half cream National Dried Milk after three feeds. Weight gain has been steady, reaching 5 lbs. 15 ozs. twelve days after admission.

Discussion

It was estimated that the infant was between 24 and 48 hours old when first seen at Guy's. The reasons for this estimate were:—

1. Ankle jerks present suggesting that at least 8 hours had passed since birth.

2. Abdominal resonance present—at least 8 hours since birth.
3. Bruises more than 24 hours old.
4. Placenta putrefying—more than 24 hours old.
5. Serum bilirubin level.

Social History

The tenement building where the infant was found is five storeys high and was built about 1880. Only half the flats are occupied, the rest being boarded up. The rubbish chute is a brick-built cavity measuring about 18in. by 12in. and running the full height of the building and emptying into a bunker outside the building at ground level. The four flats on each floor have access to the chute through a shared hole measuring 12in. by 9in., located at floor level. As mentioned previously, the infant was on top of rubbish reaching to about first floor level so that she must have been inserted at this level or above.

In their investigations the Police could find no evidence of a recent birth having taken place anywhere in the building and there were no signs to indicate which of the openings into the chute had been used to dispose of the infant. The Inspector in charge of the case said that it is common for the stairways and roofs of this and similar buildings throughout the district to be used as sleeping places by drug addicts, methylated spirit drinkers and vagrants. He thought that the mother could well be one of these types but at the present time their investigations have not discovered her identity or whereabouts.

There has only been one similar case at Guy's in recent years, and this was an infant abandoned in a telephone kiosk. It is difficult to obtain figures for the incidence of this type of case as the Registrar General's records do not separate this category from other types of abandonment in children of other age groups. The Westminster City Council Children's Department gave an estimated incidence for England and Wales of less than 5 cases per annum.

Future

To date, Guy's have received 64 offers of adoption which are being referred to the Southwark Borough Council Children's Department. When the infant is completely fit she will be taken into care and will be made a Ward of Court. She will then be placed in a Children's Home or with a Foster Mother until her adoption has been arranged.

Acknowledgments

I should like to thank all those who have been concerned with the preparation of this article, in particular, I should like to thank Sister Crump and the Staff of Diplock Ward, Mr. Michael Topp of the Medical Photographic Department; Mr. Arthur Hudson, the refuse collector who found Jane; and the Southwark Police. Finally, my thanks are due to Dr. M. C. Joseph for help with the preparation of this article.

Prize Essay Competition for Medical Students, 1966

The Council of the British Medical Association is prepared to consider the award, in 1966, of Prizes to Medical Students for essays submitted in open competition. The subject of the essay is:—"The role of the doctor in modern society." A First Prize of £50, and further prizes totalling £60 or £70 will be awarded, at the examiners' discretion.

Any Medical student who is a registered member of a medical school in the British Commonwealth, the Republic of Ireland, or the Republic of South Africa at the time of submission of the essay is eligible to compete for a prize. Previous Prizewinners are eligible for a second award. If any question arises in reference to the eligibility of a candidate or the admissibility of his or her essay, the decision of the Council of the British Medical Association shall be final. Should the Council decide that no essay entered is of sufficient merit, no award will be made.

Essays must not exceed 5,000 words; must be typewritten or legibly written in the English language on foolscap paper, on one side only; must be unsigned; and must be accompanied by a note of the name and the medical school of the entrant. The pages must be fastened together securely. Entrants should not include anything in the text which might reasonably lead to the disclosure of their identities. Notice of entry for this Competition is necessary, and a form of application can be obtained from the undersigned. Essays must be forwarded so as to reach the Secretary of the British Medical Association not later than 7th January, 1966. Enquiries relative to the Competition should be addressed to the Secretary, British Medical Association, B.M.A. House, Tavistock Square, London, W.C.1.

Johannes Brahms
REQUIEM OPUS 45
in
St. Paul's Cathedral

25th May, 1965 — Robert Sells

Of all the places in London where choral works are performed, St. Paul's has the worst reputation for acoustics; in this immense cavern a man can sing a note in the chancel and hear the echoes bouncing back and forth across the dome a full half-minute later. This effect is confusing enough for any performer, but is not so distracting as the sensation of loneliness caused by the delay of the echo (five seconds). This delay produces complete absence of "feed-back" impulses essential to any performer who is "listening in" to monitor his own performance. Further, the echo received by the performer five seconds after the noise which caused it is only of use to him in a sustained passage; in Brahms' weighty, but still brisk, allegros, great confidence and a high degree of concentration are necessary for survival. And there is the problem of the organ which sounds as though it is being played half a mile away. This cathedral is littered with the wrecks of amateur choral societies who have been confused, buffeted, and overwhelmed by the force and confusion of their own echoes. Stainer was organist at St. Paul's, and he was very wary of the acoustics when writing for his choir (perhaps this accounts for the monotony of his work). Stanford and Parry are also commemorated in the crypt, and no doubt these three spirits are gleefully totting up the score of victims.

But there are benevolent spirits here, too, for Babington and Astley Cooper are both buried in the Cathedral. In this distinguished company about five hundred of us came to hear Guy's Music Club with the Newgate Singers sing Brahms "Requiem" under Cecil Cochrane. The chorus gave a most enjoyable account of the work, and quickly came to terms with the problems mentioned above. I was particularly struck by the musical insight of the singers. Brahms, like Beethoven, found great difficulty in writing a choral score which could be sung naturally, and much of this beautiful music is often inadequately performed due to lack of appreciation of this technical point. But the sympathetic phrasing and colour of this performance did the work justice: two moments stand out as worth mentioning, the sepulchral "Behold all flesh is but as grass", and the choir accompanying Joy Strutt in the soprano solo, "Ye now are sorrowful": the former producing grimness and desperation, the latter sweetness and poignancy—two very convincing variations on the sombre theme of the work.

Cecil Cochrane's conducting is remarkable. He is a past-master at Oratorio, and perhaps he has the edge over the rest of us in that his

theological qualifications (he is a minor canon of the cathedral) enable him to develop a deeper spirituality in his performances. His sense of drama is excellent, and the success with which he transfers his ideas and intentions to performers in rehearsal is unrivalled in small choir circles. So the performance was full of vigour and contrast. There were moments, however, when one expected a big attack, and none came; when a fine rhythmic pulse set by the organ introduction was ruined by an unnecessary rallentando before the chorus entry; when chorus and soloist were imperfectly integrated for lack of a simple four-square beat. No doubt the echo accounted for much of this, but I strongly maintain that a crystal clear beat, intelligible to all, cannot be dispensed with in these difficult surroundings.

We were very fortunate to have Richard Popplewell playing the organ; his performance was perfect in its sympathy and drama. His technique is astonishingly good. Brian Etheridge's familiar, clear baritone (last heard in "The Creation") has improved since December, and his performance was admirably controlled. He produced the only amusing line of the evening when he delivered the rhetorical, "O Lord, what do I wait for?" and hastily disappeared from view, leaving the chorus to get on with it.

This very encouraging performance of a difficult work is another satisfactory achievement of a club whose record is now quite impressive. We all look forward to the next production in December.

The Future of General Practice

The Parliamentary Secretary to the Minister of Health will take this title for his subject when he delivers the Annual Lecture of the Pupil's Physical Society at 5.30 p.m., on Tuesday, 22nd June, in the Physiology Theatre. All students, pre-clinical and clinical, and any other people in the hospital who are interested, are invited to attend this meeting.

U.N.I.C.E.F.

As a result of collections made in the Spring Term, the sum of £91 18s. 2d. has been sent to the U.K. Committee for U.N.I.C.E.F. The total sent to U.N.I.C.E.F. since the Guy's collections began in 1963 is £524 17s. 10d. I have been asked by the U.K. Committee to express their warm thanks.

D. J. ANDERSON

Guy's Student Medical Education Committee

Collection of Specimens

The committee has arranged for specimens to be collected twice daily for transferal to the Clinical Pathology Laboratory. Specimens should be put in the basket provided inside the teaching room on the first floor of Hunt's House. Collection times will be posted on Firm notice boards.

Education Reports

At the meeting on 24th May, it was decided to incorporate various suggestions made by the gauleiters and resulting from the committee's discussions into a report which has now been submitted to the Dean's Office. Three Working Parties were also established to examine certain aspects of the curriculum, and details of their work will be announced shortly.

Staff Reaction

Many members of the Teaching Staff, clinical and pre-clinical, have written expressing their willingness to help the committee, and the Cardiac Department and Paediatric Research Unit said how much they would welcome students' interest in their work, and are always pleased to try and answer problems from students.

CORRESPONDENCE

Family Planning and the Unmarried

SIR, May I add my comments from a personal study of this matter (letter, page 241, 15th May). Firstly, there is great benefit to be derived from sexual continence: physical, psychological, and ethico-religious. Secondly, hardened sexual promiscuity is a problem, like delinquency, with its own now better-understood and documented background. Thirdly, let us realize that we are here only concerned, not with promiscuity, but with sexual activity prior to marriage in a milieu of moral and emotional integrity. Is this activity socially indefensible?

A too narrow advocacy of sexual abstemiousness of all sorts may at times amount to an attitude of bigotry. Each must decide for her or himself. Marriage simplifies sexuality (but not in Pauline's eyes!) from the moral point of view. To beget an unwanted child is not a crime; but it is an immoral act, and it is a serious mistake. You raised matters which have to be scrutinized charitably and with deep understanding.

Yours, etc.,

A. GRIMBLE

Guy's Hospital,
London, S.E.1.

Nubial Medulloblastomas

SIR,—I was greatly interested in the case, quoted in your latest issue, of an acute hydrocephalus in a child produced by a medullo-blastoma.

It put me in mind of an even more shattering case quoted in an article (in the *Lancet* I think) about twelve years ago. I kept the cutting for years in my copy of Willis, but it is now unfortunately lost. The impression made on me by the case was such that I can still quote the article almost verbatim. though the names and places have escaped me.

Briefly, the case was as follows: A young woman, married about six months and carrying a child, was suddenly paralysed in her lower limbs. An X-ray showed a spinal block at the level of the fourth dorsal vertebra. Exploration showed a very soft infiltrating tumour that could not be removed, but which proved to be a medulloblastoma.

At this stage the patient's husband approached the surgeon "in a state of great agitation." This was, he said, his second wife; his first, married about four years before, had died in exactly the same way. The surgeon found this hard to believe and tried to reassure him. On investigating the previous case, the following facts were, however, established. The first wife, about the same time after marriage and similarly carrying a baby, had developed paralysis of the legs and had been found to have a spinal block at the level of the fourth dorsal vertebra which proved on exploration to be a medulloblastoma and could not be removed. Sections of both cases were published in the article, and, as the surgeon remarked, allowing for differences in fixing and staining, they were undoubtedly both the same kind of tumour. Both women and babies died.

The surgeon remarked, medulloblastomas are rare tumours at the best of times, and the occurrence of two in this manner must constitute a coincidence that makes the proverbial "blue moon" seem a common occurrence. The only alternative, however, is so contrary to all orthodox thought in the subject of tumours, that the mind at once rejects it.

Well, what advice would you give to the husband if he wanted to get married a third time? Thank God, I didn't have to decide that one! Perhaps one of your readers may remember the case, and give us chapter and verse.

Yours, etc.,

J. W. SHACKLE.

14, Moneyhill Road,
Rickmansworth,
Herts.

REVIEWS

AIDS TO PRACTICAL NURSING.

by Houghton and Whitton. Bailliere, Tindall and Cox. London, 1965. 10th edition. *Price* 10*s*. 6*d*.

This small book could be recommended to student nurses as a standard text book on practical nursing. It could also be used as a reference book for pupil nurses. The subject matter adequately meets the requirements of the practical nursing syllabus of the General Nursing Council. It is well set out under headings. Diagrams and illustrations are well chosen and clear, those on lifting being particularly worthy of mention.

The book is printed on good quality paper, and the print, though small, is easy to read. There is the occasional printer's error, for example, on page 136 the word "certainly" appears where "certainty" is obviously intended. On the whole, however, the disadvantages are those of any paper-back edition and these are offset by the big advantages of cheapness of production.

D. MACHIN

UROLOGY FOR NURSES.

by J. P. Mitchell. John Wright, London, 1965. *Price* 19*s*. 6*d*.

So few are the books dealing with urology from the nurse's angle that any new publication is welcomed eagerly. This small volume will be a boon to students and trained nurses working in urological wards and departments; hard-backed and sturdy, it is not too big to be carried in a capacious uniform pocket. In twenty short and succinct chapters the author never loses sight of the nurse's needs. A good index makes it easy for her to find clear, concise information quickly. Student nurses being initiated into the mysteries of the cystoscope will find chapter four, like all others profusely illustrated with line drawing and photographs, invaluable. Straightforward directions are given on sterilization of cystoscopes, with a salutory warning about the necessity for thorough cleaning beforehand. The dangers of surgical diathermy are discussed fully and there is a horrifying photograph of a diathermy burn. Readers who have nursed patients undergoing peritoneal dialysis at Guy's will question the statement that "a general anaesthetic must be given" and they will be repelled by a singularly inelegant sentence which appears on page 166. It starts "A female who has been perpetually wet from an incontinent bladder can have considerable encouragement from an interview with another similar victim . . . " But these are only trivial objections to an excellent, informative little book. At its remarkably low price it will surely gain the popularity it deserves.

G. BURNHAM

DIETETICS AND NUTRITION.

by Z. Baker. 1st Ed. Faber & Faber. Pp. 222. *Price* 25*s*.

The main part of this book, described as a " text-book for nurses and dietitians," consists of an elementary introduction to Human Nutrition, and simplification has produced some rather misleading statements. The qualitative and quantitative aspects of each nutrient are discussed in separate chapters, resulting in a good deal of repetition, and the numerous tables of figures inserted throughout seem too comprehensive for the level of the text. The second part covers the dietary requirements in health and disease. The advice given here is mainly sensible and up-to-date, although the choice of 1800-2000 calories for the standard reducing diet seems unusual. At the end are diet sheets, recipes and tables of the chemical composition of general and proprietary foods. References from recent publications are given, but more suggestions for further reading might have proved useful. The general layout and index are fair; binding, printing and paper are very good.

P. M. NEWLAND.

A GUIDE TO ORTHOPAEDICS

by T. Stamm (2nd Edn.). Blackwell, Oxford. Pp. 118. *Price* 18s. 6d.

I have read this book from cover to cover with great enjoyment. It is not a comprehensive text book, but the views of an extremely experienced orthopaedic surgeon on certain orthopaedic problems. These are set forth so clearly that this book should be read and understood by all students of medicine, physiotherapy and occupational therapy. The chapters on the foot and minor foot disorders are explained with clarity, simplicity and sweep away the confusion which exists concerning their treatment. The chapter on chronic arthritis describes the changes and symptoms of osteoarthritis, and surely all those people who give physical treatment for this condition will echo Mr. Stamm's plea for a more specific diagnosis when prescribing treatment. I would recommend this book for anyone who has to deal with orthopaedic problems

CLINICAL DIAGNOSIS IN LABOUR.

Hamlin. Livingstone. 2nd Edn. Pp. 178. *Price* 20*s*.

The second edition of this small textbook contains quotations, brief histories and telegraphic print. In addition, about twenty pages of diagrams illustrating examination per rectum, emphasising the need for more frequent such examinations as a prelude to correct diagnosis in labour. In my opinion rectal examination cannot replace vaginal examination, for a finger through the rectum has to feel through the glove, rectal wall, pelvi rectal fascia and vaginal wall. The first three chapters have a wealth of knowledge on spot diagnosis by patient's general physical appearance. It is a good book to glance through before taking on an obstetric house appointment, but not for medical students.

M. A. Q. JAMIL.

MEDICAL BACTERIOLOGY.

Whitby and Hynes, by Martin Hynes. Churchill. 8th Ed., 1964. Pp. 495. *Price* 40 shillings.

This well-known book is a concise, yet quite detailed account of bacteriology, and includes sections on mycology and parasitology. Numerous revisions and additions have been made in the text, including the chapter on antibiotics and chemotherapy, where a brief glossary of some of the individual drugs is given.

The medical student will find " Medical Bacteriology " a very useful and lucid book since emphasis has been laid on general principles of bacteriology and on the aspects of this subject, which are important in the understanding and application of clinical and preventative medicine.

J. W. B. FRANKLIN.

THE NURSING OF ACCIDENTS.

by R. Farrow. English Universities Press, 1965. *Price* 8*s*. 6*d*.

This new paperback deals very comprehensively with a wide range of accidents and their nursing care. The text gives a clear, if somewhat wordy, description of injuries, their cause, mechanism and treatment as seen from the nurses' point of view. The line drawings are very clear. This book is obviously good value for money. but being in the form of a paperback the binding is frail and the text closely printed. The paper does not allow for the reproduction of X-ray plates, which can be very helpful to the nurse in her understanding of orthopaedic injuries. If the nurse wishes to purchase her own textbook in this subject I would recommend this book. For purposes of reference only, there are other recent publications at a higher cost, which may prove more helpful.

P. D. FORD

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SPORT

ATHLETICS

Sports Day was held on Saturday, 29th May, and, in spite of the cold and overcast conditions, a very good crowd turned out to watch the events.

Considering the soft condition of the track, caused by the previous week's rain, some very good performances were recorded. The only record which was broken was in the hammer. G. Edwards improved on the existing record by some sixteen feet, and P. Peace, who was placed second, also bettered the existing record. In the middle and long distance events, J. Wheeler ran well to win the mile and two miles from P. Witting. D. Choat won the 880 yds. in a very fast time with Wheeler taking second place.

In the hurdles, A. Winskill gained a comfortable win from I. Morgan, but this order was reversed in the 440 in which Morgan ran a well-judged race in the outside lane to improve on his previous year's time.

The 100 yds. provided an exciting finish with D. Barford just beating F. Nwator on the line. Barford was also placed first in the 220 yds. with I. Morgan second, and in the jumping events, R. Morris jumped well to clear 6 feet with W. Annan and A. Waring equal second. In the long and triple jumps, I. Morgan further demonstrated his versatility by winning the former and coming second in the latter. M. Bates jumped well to win the triple jump, and this event provided three athletes capable of jumping over forty feet. In the throwing events, P. Peace again dominated the shot and discus with J. Ross gaining second place in the former event.

The javelin was won by B. Hartley with a throw well below his best. A. Winskill gained a very creditable second in this event. In the pole vault the proceedings were hampered by a lack of poles of sufficient height on which to place the bar. However, after some courageous vaulting, W. Annan emerged as the winner from G. Edwards, while in the relay, the Tubules, thanks to some spirited running by Hartley and Lang, gained first place from the Rugby and College teams which were second and third respectively.

The Victor Ludorum was won for the second year in succession by I. Morgan. As a result of his versatility in a wide range of events, he gained a comfortable points margin over G. Edwards and A. Winskill, who were both placed second.

Reports and Results

CRICKET

GUY'S v. INCOGNITI

At H.O.P Tuesday, 25th May, 1965
Result: drawn

Incogniti won the toss and elected to bat. The opening pair, against a rather mediocre attack, saw the 50 up in even time. A useful run-out, followed by a quick wicket by Appleby in his usual style, were the only wickets taken before lunch. After lunch Davoodbhoy bowled well, taking in all four wickets. A fine innings by Barker of 79, and a quick 22 by Javsey, who was dropped no less than three times in the last over, enabled the Incogniti to declare rather belatedly at 240 for 9 wickets.

Guy's chasing a large total, soon lost Butchey, followed in quick succession by most of the other early order batsmen. However, Crafts 34, and Griffiths 42 batted well, bringing the score to respectability. They were followed by Appleby and Davoodbhoy, who also batted well. A fine rearguard innings by Neville enabled Guy's to play out time, ending up with 159 on the board for the loss of eight wickets.

Scores:

Incogniti, 240—9. (Barker 79; **Walker**, 47.) (Davoodbhoy, 4—87.)

Guy's, 159—8. (Griffiths, 42; Crafts, 34; Appleby, 24.)

D. B. A SILK

GUY'S v. DOVER

At Dover Saturday, 29th May, 1965
Result: Guy's lost by 8 wickets

Batting first on a fair wicket, at the County ground, Dover, Guy's lost Butchey in the first over. But Crafts and Cutler put on 48 for the second wicket until the former was adjudged l.b.w. Thence followed collapse, and but for Cutler's 43 and a last wicket stand of 30 between Davoodbhoy and Beacham, the Guy's total would have been paltry.

As it was, 102 was nothing like enough, though the Dover batsmen made very hard work of it. Beacham and Davoodbhoy bowled well, and the team fielded well in the bitterly cold weather. When Dover were within 10 of our total, for the loss of only two wickets, the batsmen were still showing a marked

reluctance to hit even half-volleys. However, at this stage, the captain, in an effort to speed his journey to the bar, brought Silk, Powell-Jackson and Cutler on to bowl—even they bowled five overs before the last 10 were scored! In fact, in all, Dover required 48 overs as against Guy's 33 to score 103 runs.

Scores:

Guy's: 102. (Cutler, 43; Crafts, 19; Davoodbhoy, 19 n.o.; Beacham, 10.) (Bowes, 6—46; Smith, 4—34.)

Dover: 103—2. (Austin, 42 n.o.) (Davoodbhoy, 1—21; Beacham, 1—42.)

J. K. CRAFTS

GUY'S v. HIGHLAND COURT

At Highland Court Sunday, 30th May, 1965

Result: Guy's lost by 73 runs

After an eventful Saturday night, Crafts took the expected course of giving the opposition first use of a damp wicket.

Knott, Beacham, and Davoodbhoy all bowled well, and with the help of some good fielding, had claimed six wickets for 80 runs by lunch. Afterwards, Guy's rather let the opposition off the hook, and allowed their last four wickets to double the score.

Chasing 160 at a run-a-minute, Butchey and Crafts opened steadily. The stand had reached 40 before Highland Court brought back Jones, who played for Kent up till last year, and Shepherd, a West Indian, who is qualifying for the County. These two bowled throughout the rest of the innings, as Guy's struggled to reach a total of 87. After the opening had gone, Silk was the only batsman to put up any prolonged resistance.

Highland Court were undoubtedly one of the strongest sides Guy's will meet this season, both in batting and bowling. We had done well to bowl them out for 160, but our batting proved too inexperienced to cope with their attack.

Scores:

Highland Court: 160. (Marshall, 43.) (Davoodbhoy, 4—37; Davies, 2—10; Knott, 2—34; Beacham, 1—55.)

Guy's: 87. (Crafts, 26; Butchey, 15; Silk, 19.) (Jones, 5—20; Shepherd, 4—24; Wilson, 1—3.)

M. I. APPLEBY

TENNIS

The Hospital is having its most successful season for many years, and has lost only one fixture, a hard and close fought game with Imperial College 1st VI.

Over the Cambridge week-end, we romped through Queen's 8—1, but made hard work of St. John's, winning 5—4, on a most unpleasant day. The following Tuesday the team played an evening fixture against Royal Naval College, Greenwich, on their excellent courts, and won 5—4, afterwards having a most enjoyable evening.

On Saturday, May 22nd, we entertained Bart's and came out on top. Although we won 7—2, in all matches, except those against their weak third couple, the play was even and could have gone either way, and let the team be in no doubt that should we play them in the Cup they shall have a strengthened team and more determination. The following day we lost a good match to Imperial College, 5—4, after five of the nine matches had gone to three sets. For the first time this season the third pair did not register a win—let alone two or three.

On Wednesday, 2nd June, a weakened 1st VI defeated George's 6—3.

An unfortunate aspect of the season has been the cancellation of the fixtures with Public School Old Boys and Midland Bank, because of their inability to raise a team. The 2nd VI has had similar problems, which is unfortunate, as this year there are many players both willing and able. Our first Cup match against King's has had to be postponed to June 9th.

Outstanding in the 1st VI has been John Hopkins, in an above-average group of players as witnessed by the large entry for the Hospital singles competition.

H. C. SHARP

SWIMMING

GUY'S v. LLOYDS

We were very pleased to entertain Lloyds again after a break of two seasons. A hard match was expected, and so it turned out to be.

Guy's badly missed the speed of R. Jones in the middle of the pool, and for the first quarter were severely hounded by Lloyds.

From the few break aways Guy's had, they managed to score two goals, both by Barnes.

The second quarter was better for Guy's as they began to take more control of the game. No goals were scored in this or the third quarter, which was all Guy's.

In the last quarter, two very tired teams slowed down the pace, and made the game more positive in approach. Barnes scored a good solo goal, and then picked up a long pass to make the score 4—0. Lloyds closed the scoring with a solitary goal.

This was a good match and showed up the weaknesses of Guy's when the full side cannot be mustered. Although it was very pleasant to score our first win over Lloyds, it should not have been such hard work.

Team. I. Siegle (goal), D. J. C. Barnes, R. McGlynn, D. Bartlett, I. Peter, A. Forbes, D. Harn, B. Valentine (Capt.).

B. A. VALENTINE

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S-MAUDSLEY NEUROSURGICAL UNIT

Applications are invited for two posts of **Senior House Officer** (resident), one for the six months commencing 1st August, 1965, and the other for six months commencing 1st September, 1965. The Unit, which is housed in the Maudsley Hospital, serves both Guy's Hospital and the Bethlem Royal Hospital and the Maudsley Hospital. Applications should be made by the **26th June, 1965,** to L. H. W. Paine, House Governor and Secretary, The Maudsley Hospital, Denmark Hill, S.E.5.

GUY'S HOSPITAL, S.E.1.

Applications are invited for the following appointments to commence duties on 1st October, 1965:

Department of Conservative Dental Surgery

Full-time Registrar;

Registrar to attend on five sessions per week for the period 1st October, 1965, to 31st July, 1966.

Department of Dental Prosthetics

Registrars to attend on six, four, or three sessions per week.

Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, London, S.E.1, not later than **Saturday, 26th June, 1965.**

PASS LISTS

UNIVERSITY OF LONDON

3rd M.B., B.S., April, 1965

Honours

Jennifer A. Chown (Distinguished in Surgery).
B. H. Hicks (Distinguished in Applied Pharmacology and Therapeutics).

Pass

I. A. Baker
S. Bhanji
Jennifer A. Blyth
J. G. Cochrane
P. D. Davies
P. J. Dickinson
C. G. C. Gaches
P. Garcia-Webb-Sharp
R. Gilkes
Carol G. E. Gladstone
J. M. I. Iveson
T. B. W. Johnson
L. Levinsky
M. F. Lewis
I. A. Mackenzie
I. C. M. MacLennan
A. H. Mowbray
L. C. Nash
Suzanne E. E. Peet
R. A. Y. Pietroni
A. M. Roberts
P. B. Robinson
Patricia V. Rowntree
P. J. Rowe
J. P. Sedgewick
P. Sheridan
P. C. Smith
A. Stevens
M. Thomson
P. A. Ustianowski
M. Walter
Dawn G. G. Woodruff
Christina M. Wotherspoon
Rowena C. Yates

Part 1

P. J. C. Baxter
D. H. Evans
J. W. B. Franklin
J. S. Gregson
A. Kuczynski
C. E. M. Lamb
W. T. Lamb
Christina J. R. Lawrie
T. N. D. Peet
G. G. Simpson
M. S. Vernon
Carol M. E. Williams
P. A. D. Williams

Part 2

M. B. Barnett
A. J. Hazzard
M. J. Hoyle
B. J. Mason
A. W. J. Medhurst
G. J. D. Moore
H. Munitz
M. W. J. Older
Jennifer P. Pearse
R. A. Sturge
I. A. Sutherland

Part 3

R. F. C. Boger
L. D. Edwards
D. H. Evans
G. F. Falconer
M. J. Hoyle
Christina J. S. Lawrie
G. J. D. Moore
D. J. O'Gorman
M. W. J. Older
J. C. Robertson
I. A. Sutherland
R. H. Thacker
Carol M. E. Williams

Part 4

M. B. Barnett
P. J. R. Boyd
L. D. Edwards
D. H. Evans
G. F. Falconer
A. J. Hazzard
C. W. Howell
C. G. D. Johnson
S. J. L. King
A. Kuczynski
Christina J. S. Lawrie
B. J. Mason
A. W. J. Medhurst
H. Munitz
D. J. O'Gorman
M. W. J. Older
Jennifer P. Pearse
J. C. Robertson
Sophie Robertson
I. A. Sutherland
R. S. Vine
Carol M. E. Williams

SCHOOL OF PHYSIOTHERAPY

May, 1965

The following students have passed the final examinations of the Chartered Society of Physiotherapy:

Barger, C. M.
Bugbird, H. M
Cook, G. G.
Crews, M.
Girdlestone, A. J.
Hale, J.
Lean, V. J.
Seaman, D. J. D.
Williamson, A. S., with credit.

PAPERS BY GUY'S MEN

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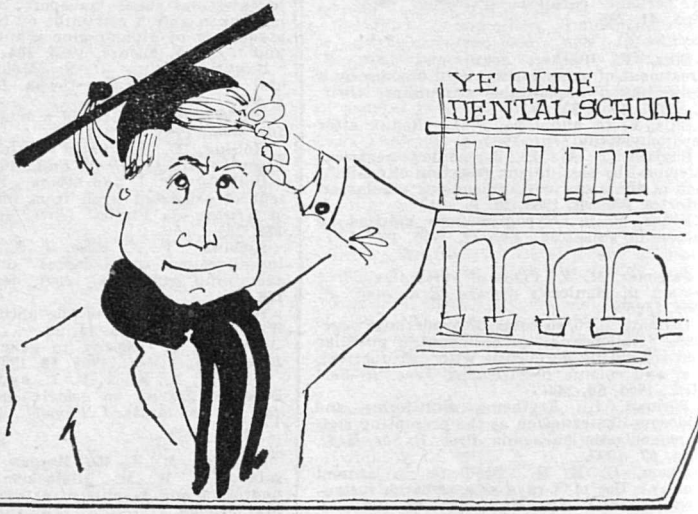
AFTER GRADUATION... WHAT?



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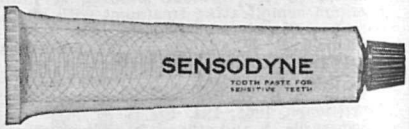

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GUY'S HOSPITAL GAZETTE

FORTNIGHTLY ONE SHILLING VOLUME 79 NUMBER 2007

26th JUNE 1965

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EDITORS P. BOWDEN AND A. E. RAYNES

SPORTS CORRESPONDENT A. PROCTER

GUY'S HOSPITAL, LONDON

PASSIM

Division by Conscience

After debating the matter twice and hearing more than forty speeches, the House of Lords gave a second reading, by a majority of forty-five, to proposals on the reform of the law relating to homosexual practices. The Commons, however, after two ten-minute speeches, rejected the motion by a majority of nineteen. It was a free vote in that conscience, not party politics, was the guide to division and yet the Church Assembly, the Roman Catholic Advisory Committee, the Methodist Conference, the Church of England Moral Welfare Council, as well as leaders of both the medical and legal professions, including Lord Brain and Lord Delvin, had all supported the Wolfenden Committee's recommendation for reform. Thereby the people rejected the leadership of the Churches, who are the traditional guardians of ethical principles in our country.

Surely we are not socially naïve enough to believe that by removing this ill-conceived clause of 1885 from our statute books we will unleash the undesirable in man and so bring about the collapse of our civilisation, like Nero's. In all probability there are half a million male homosexuals in Great Britain who are oppressed by a law that does not exist for their female counterparts and by the continuance of its validity the public hopes to protect itself from something whose existence it wishes to ignore.

In the Passim of 5th September, 1964, the hope was expressed that the time had come to "mitigate their sense of social isolation, ostracism, guilt and shame", but it was not to be so. Reform was in the air but it was blown away by the bigot's purist coughs. The winds blew in the minds of the people who had denigrated their name and yet for them there is still to be no release and they remain shackled as were the schizophrenics. For a time they remain a scapegoat, a threat of depreciation to society and a lesson to the young. It should be repressed by the individual conscience which is fully aware of the consequences of sexual deviation. A writer in a medical journal made the point that the high incidence of venereal disease amongst homosexuals may be due to their knowledge of the "extent of the prejudice against them and fearing exposure and the severe penalties of the law against homosexual acts, some of these men are deterred from coming for treatment and so remain a danger to themselves and to others." The trait is in all of us.

In the Birthday Honours list published on 12th June, Sir Russell Claude Brock, M.S., Hon. F.A.C.S., Hon. F.R.A.C.S., President of the Royal College of Surgeons of England, was awarded a Barony for life.

Dr. J. Fraser Roberts, F.R.S., has received a C.B.E. in the Birthday Honours List. Dr. Roberts retired from his appointment as Director of the Medical Research Council's Clinical Genetics Unit at the Hospital for Sick Children, Great Ormond Street, in October 1964, to become Geneticist to the Unit and Honorary Clinical Geneticist to Guy's Hospital.

Indisposed

The tides of affluence have washed in an age of disposable bric-à-brac, which is burying the last gems of Victorian conservatism beneath waste paper on Brighton beach.

Surgical instrument manufacturers joined the band wagon long ago. The words "disposable, use once only" on a wrapper are now so familiar that they have already secured a place in the verbal sewage system of things no longer read. The difficulty in using these instruments lies not in the imperfections of their manufacture but in acquiring a value to them and overcoming worn attitudes of preservation. It is only with restraint that some prevent themselves washing the instruments before disposal or lose sleep trying to think of a second use for them (dreams of disposable district nurses inflating their bicycle tyres with large plastic syringes), while the extremists, crazed with affluence, stealthily pocket the instruments and hurry off to jump on them on a concrete floor. One way of keeping these things in correct perspective is to cultivate a disposable attitude. This can be developed by joining the many thousands of people who spend the August bank holiday practising the art of disposal all over England's beauty spots.

These are just the beginnings. The disposable motor car is already on the drawing board, and "plug-in" cities have reached the colour supplements. At the hospital level the ultimate conclusion would be the regular delivery of disposable operating theatres, ready for use, complete with staff and the whole lot wrapped in polythene.

Humphrey Ashley Hope, M.B., B.S.Lond., B.D.S., has achieved the distinction of Constable of the Town and Manor of Hungerford, the office was established in 1395 when John of Gaunt granted Common Rights to the town's inhabitants.

GUY'S DIARY

JUNE.		
Exhibition.		*Conjoined Twins.*
26th S.	10.00	Clinico-Pathology Meeting in the Demonstration Room.
28th M.	1.00	Sir JAMES PITMAN, K.B.E., M.A. Clinical Lecture. *"The Initial Teaching Alphabet."*
29th T.	1.00	Dr. VAUGHAN. Clinical Lecture.
JULY		
1st Th.	1.00	Mr. GLOVER. Clinical Lecture.
6th T.	1.00	Mr. CLARKSON. Clinical Lecture
8th Th.	1.00	Mr. LAWRIE. Clinical Lecture. *"Oral Cancer."*
12th M.	1.00	Mr. TOMKINSON. Clinical Lecture.
13th T.	1.00	Dr. WAYTE. Clinical Lecture.
15th Th.	1.00	Mr. WASS. Clinical Lecture. *"Swellings in the Scrotum."*
16th F.	1.00	Dr. KAUNTZE. Clinical Lecture. *"Dyspnoea."*

RETIREMENT OF MR. E. G. SLESINGER, O.B.E., M.S., F.R.C.S., B.Sc.

Chairman of the Board of Governors Guy's Hospital

On May 31st last, Mr. Slesinger retired from his high office as Chairman of the Hospital. He retired from the active surgical staff twelve years ago and that was the occasion to remember especially his long clinical service to Guy's and his personal associations with patients, students and colleagues in his professional work (Guy's Hospital Gazette, 21st March, 1953). But for many years before then he had also played a great part in the administrative and policy-making work of the Hospital and School. He became Chairman of the Medical Committee and of the School Council in 1943. His clinical colleagues will always remember the gracious setting in which the Medical Committee met in the days of his chairmanship. In the seclusion of his own home, with coffee before, and other things after the meeting, he both entertained and presided over the gathering; difficult problems and delicate situations resolved themselves with remarkable ease in the atmosphere of a host who was welcoming his guests.

The interests of the Hospital and of the Medical and Dental Schools are, of course, inseparable. In the first few years of his chairmanship of the Medical Committee and of the School Council Mr. Slesinger's grasp of these common interests played a great part in maintaining the happy relationship that had always existed. At that time the Medical and Dental Schools had no ultimate existence apart from the Court of Governors of the Hospital, and if there ever had been an impasse between these two institutions there could have been no doubt who would have had the final word. With the introduction of the National Health Service in 1948 the Medical School became an autonomous entity, and it was fortunate for Guy's that the chairmanship of the Medical Committee and of the School Council was with Mr. Slesinger at the time of transition. His knowledge of every detail of Hospital and School activities and his acute perception of essential things ensured that the new status of the School would be turned to strengthening the ties with the Hospital in the future. By the time he retired from these two committees in 1953 he had the satisfaction of knowing that, under the new conditions, the old, happy relationships were stable and secured for the future.

Mr. Slesinger had made Guy's daily problems and future welfare so much a part of his life, and had become so identified with the institutions which he served that his retirement from the active clinical staff in 1952 would have left an empty prospect for any man who had less than his capacity for keeping youthful. Instead of resting on his oars, he undertook, with undiminished energy, the duties of a very active Governor of the Hospital. He had been a Governor of the Medical School since 1948 and a Governor of the Hospital since 1946.

In 1948, when the new Board of Governors was appointed under the National Health Service, he became its Vice-Chairman, and his great knowledge of the Hospital and of its personalities was applied to assisting the then Chairman, Lord Cunliffe, in the integration of the old with the new. Mr. Slesinger had, during the latter years of the War, played a major part in the post-war planning committee, and when the War was over he became Chairman of the Building Committee which was shaping the future Guy's. This committee developed

the "Snowflake" plan and although in the end this scheme did not proceed, from it was evolved the form of ward which we now have in New Guy's House and that building owed a great deal to the ideas and decisions of the first scheme.

As well as being, for a time, Chairman of the Finance Committee, he became Chairman of the Building and Plant Maintenance Committee which deals with all works of alteration and adaptation in the Hospital as well as with the day-to-day care of its fabric. To him Guy's owes its greatly improved Central Kitchens and a model food stores and bakery. When Lord Cunliffe became ill he acted for him and, following Lord Cunliffe's death in November 1963, the Minister of Health departed from precedent by re-appointing a Governor who had already served past the normal retiring age and Mr. Slesinger became unique in being the first medical man to be Chairman of Guy's.

Mr. Slesinger has a remarkable facility for getting to the main point of a problem and for keeping clearly in mind the arguments leading to a course of action. His clear mind had already seen the benefits of the proposed amalgamation of hospitals in the Bermondsey and Southwark area with Guy's and the consequent acceptance of district responsibility by an enlarged teaching hospital group. During his period of office he furthered this scheme so that now it is moving towards the concluding stages of official consideration. He was positive in his chairmanship and took pride in seeing that business was carried out efficiently and effectively with no more discussion than was necessary. He had no wish to concern himself with the detailed administration of the Hospital, but this did not prevent him from pursuing with great tenacity minor matters which he thought were not being dealt with promptly and effectively.

On his appointment as Chairman, he made it clear that when a younger man could be found who was suitable and willing to accept the responsibilities of the chairmanship of Guy's, he would stand down. In putting the interests of Guy's before all personal considerations he has rendered still further service to the Hospital by making possible the appointment of Lord Robens as his successor.

It was unquestionably a pleasure that on Mr. Slesinger's last day of office Lord Robens could join with his fellow Governors and co-opted members of committees in wishing him well on his retirement and Mr. A. B. Orchard-Lyle, Vice-Chairman of the Board, presented him with a silver salver inscribed with the signatures of all his associates on the Board. Former colleagues and other members of the staff, both past and present, joined in a presentation which was made by Sir Rowan Boland on the 9th June. The cheque which he presented was a tangible token of regard from Guy's men and women both in this country and abroad.

After nearly sixty years at Guy's, Mr. Slesinger might understandably feel the deprivation that must come with his retirement as Chairman of the Board of Governors. We hope that this will only be a very fleeting feeling on his part and that his active and energetic mind will find new ways of occupation, perhaps in putting on paper his recollection of this Hospital over so long a period and in so many roles.

A POISONS INFORMATION SERVICE

R. GOULDING

Doctor! Mum has been cleaning the toilet with lavatory cleaner and bleach and has now collapsed, gasping for her breath, in the smallest room in the house—what should I do? Tell me, Grandad has stuck in his false teeth with Bostik—will it hurt him?. Our little girl has found the contraceptive pills and has eaten three or four of them—what will happen to her? Janet has taken some of my nerve tablets—will they do her any harm? The boys have been playing in the tool-shed and Georgie says that Herbert has drunk some of the paint thinner—should we do anything about it?

This is a fair sample of the questions directed at the Poisons Service, out of a total of 2,100, during its first year of operation. Their nature, variety and oddness will surprise no one in general practice, nor, for that matter, any recently qualified graduate who has spent more than a week or two in a hospital casualty department. One never ceases to be amazed at the diversity of substances that people take inadvertently (or deliberately), or become exposed to during their work or play. Neither the undergraduate curriculum nor the available textbooks can cater adequately for all these eventualities. The seasoned practitioner has often accumulated sufficient wisdom, as well as experience, to make up his mind pragmatically in situations of this sort. But from time to time even he will feel bewildered. The more so will be the lot of the comparatively unseasoned resident.

A Government Committee. There is nothing new about government committees; they represent an all too conspicuous feature of contemporary social activity. The cynics have observed that they are no more than a respectable device for putting off decisions. Not all of them, however, attract this denigration. Perhaps the individual membership does count for something after all. At any rate, in 1959 there came into being (to give the full and imposing title) a special sub-committee of the Standing Medical Advisory Committee of the Central Health Services Council, charged with considering " . . . the arrangements for the emergency treatment of cases of acute poisoning in hospital, and to advise upon them." That a few, clear-cut recommendations should ever have been reached after such a ponderous start might conceivably be due to the fact that, out of a total membership of ten, no less than three were Guy's men—Dr. Douthwaite, Professor Keith Simpson and Professor Atkins, who was chairman.

The Facts. Before coming to any conclusion the Committee, not unreasonably, surveyed the scene. Their report is well worth reading simply for the data presented. They found that about 5,000 people

in England and Wales died each year from poisoning—about the same number that met their death on the roads. They observed, too, that the figure was rising each year, that the commonest causes of fatal poisoning were carbon monoxide, barbiturates and aspirin, that the mortality figures represented only a small proportion of those people who had been poisoned (perhaps less than one-in-ten) and that "the number of poisonous preparations on the market is growing so rapidly that although they are issued in various forms and colours, their recognition is becoming extremely difficult. Moreover, many more substances have been introduced into horticultural use, for instance as insecticides, and in domestic use as cleaning and polishing agents. Frequently the chemical composition of the latter is known only to the manufacturers."

The Proposals. Arising from their deliberations, the committee proceeded to enumerate six specific proposals, only two of which are for the moment directly relevant, namely:—

An information service on poisoning should be set up with central arrangements for co-ordination.

The increasingly rapid appearances of new drugs makes it desirable to have a centre for academic research on toxicology. This recommendation should be discussed with the Medical Research Council.

Poisons Centres. To implement the first of these recommendations meant the establishment of so-called poisons centres. There was nothing original in this, as the committee itself pointed out. Such centres, in fact, had been in existence in the United States and Canada for some years, the first in the world probably being that in the Presbyterian St. Luke Hospital, Chicago, which was started in 1953. Moreover, even in Britain, local efforts had already been made along these lines, notably in the Casualty Department of the General Infirmary at Leeds. The British Paediatric Association was also agitating for something to be done. The implementation of the Atkins' Committee's suggestions, however, led to the first nationally organised, comprehensive service to meet this need.

Negotiations. The layman may assume that when action follows decision in a government department, the procedure is always strictly formal. Far from it. Even the Ministry of Health can show some flexibility and Guy's has a renowned ability for adaptation. As a result of a few discussions, in which Sir Rowan Boland and Professor Keith Simpson figured in the first instance and into which the Superintendent, the Matron and the Clerk to the Governors were later drawn, the focal point of the new Poisons Information Service became located at Guy's. It is to be found in the Medical School—though its prime purpose is not that of teaching; it is housed with Forensic Medicine, though it is not *of* that Department; it functions to some extent as part of the hospital, though its ramifications extend throughout the United Kingdom. To carry the apparent "irrationality" even

further, it really has hardly any staff as such, only a large number of helpers, all of whom have some other job in life, not excluding the young secretary who, on emerging from her training, discovered that she was called upon to exercise two by no means distinct allegiances, one to poisons and the other to jurisprudence. It says much for her ability and accommodating manner that she has survived nearly three years of this without signs of wilting nor of giving the wrong answer!

The Index. According to the records, the remit of the Service was :

(i) To maintain an index of substances in common use—medicinal, agricultural, horticultural, household—showing their composition and, wherever possible, their toxicity and corrective measures in cases of poisoning.

(ii) To provide information to medical practitioners so as to facilitate treatment of cases of acute poisoning.

Someone had the audacity to suggest that these directions were drawn up simply for publicity purposes after the index had been constructed and the Service was about to operate !

Anyway, there **is** actually an index, such as that outlined above. In its compilation, advantage was taken of the one already in existence at Leeds, by courtesy of the authorities there, to whom acknowledgment is now gratefully made. But the opportunity was taken to check, amend and extend the entries, particularly with regard to the clinical aspects.

Advice Given. This brings one to the crux of the Service. What, exactly, should it do? At the start enormous care was taken to avoid any impression that directions were being given to practising doctors about the manner in which they should treat individual patients. The Service, it was stressed, should offer facts; the doctor would then employ these to decide for himself on clinical action. In brief, the index should be little more than a list of contents. Advancing cautiously, a trial start was made with this service even before the official opening date. It was not long before an enquiry was received about a child having sucked, or swallowed, a small quantity of a particular proprietary product. The answer, accordingly, was given. It was that it contained:—

	%
Abracol G.M.S.	66.01
Cetyl alcohol	2.03
Wool fat	0.93
Silicone antifoam emulsion, type "B" ...	0.03
Ultramarine B and F, 531/n	15.00
Yellow oxide, 5 F.S.—I.C.I.	0.60
Black—vegetable	0.40
Empicol L.Z. powder	15.00

Incidentally, this is a particularly glamorous cosmetic, but no prize is offered for correct identification. Little wonder, though, that the general practitioner, in a state of indecision about the fate of his little patient, should react, not with gladness for having been given this remarkable insight into the composition of the "poison", but with a few terse comments that he must have picked up in medical school, though not necessarily from the academic curriculum !

So we had to mend our ways. Today, the vital part of the index sheets, which number in all some 6,000 items, is concerned with the degree of acute toxicity (including a figure for the fatal dose, if that can be approximated), an indication of the principal symptoms that may arise from acute overdosage and a brief outline of the treatment. To convey this is, perhaps, tantamount to offering clinical advice or to acting as consultants over the telephone. If so, that is what the doctors appear to want—and nothing less (even if sometimes they ask for more). At the same time we, as purveyors of the advice, are safeguarded, for we make a point of dealing only with medical practitioners. Granted we can be deluded, especially when we have no means of meeting the enquirer face to face. But in principle, at any rate, we do not deal with the general public, although we are well aware that in the United States and Canada that is the rule. Over here, we think that circumstances are different. It is seldom that anyone is quite beyond the reach of a doctor or hospital. In North America, by contrast, there are vast areas of land without any medical personnel and folks have to fend for themselves. General practitioners, too, are at a premium (though this may be a delicate factor on which to touch in England now) and large populations of the less privileged have no doctor at all. Their poisons centres accordingly give first aid advice to all and sundry. We play it safe. We always instance the case, fortunately hypothetical, of the baby-sitter telephoning and saying that the child has swallowed a lot of small white tablets from a bottle labelled saccharin. We might well counsel reassurance, only to discover next morning that the child is dead because the tablets were in fact barbiturates transferred carelessly from the fragile cardboard box ("skillet" in the vernacular) in which they were supplied to the empty saccharin bottle, without the precaution of altering the label. The doctor on the spot, knowing the personalities, is better able to assess the position, and it is he—not we, many miles away—who assumes ultimate clinical responsibility.

Who handles the calls? At Guy's, about forty calls a week are received. These are not enough to justify the allocation of qualified personnel to staff the centre throughout the twenty-four hours. So, paradoxically, considering that enquiries are accepted from doctors alone, the answers are given during the day by secretarial members of the centre and overnight and at week-ends by nurses on duty in the intensive therapy ward. It is salutary to note that these people unaided are able to cope with the majority of the calls. They derive their answers primarily from the index which has already been described.

But no claim is made that this index is an inexhaustible mine of knowledge. It caters for what usually happens and, fortunately, common things occur commonly. Yet there are, and must be, more unusual queries. For these another source of information must be provided. So the index is supplemented by a series of reference books, covering industrial chemicals, household goods, drugs, poisonous plants and so on.

Even with all these texts at their command, the first-line answering staff may sometimes be at a loss. The query may concern something of which no trace can be found, or the caller may wish to discuss further clinical implications. A second line of expertise is therefore provided. At Guy's this is furnished by the anaesthetic registrar on duty. By his very training and experience he is versed in both applied pharmacology and the practice of resuscitative and supportive measures, which are the very essence of management in cases of poisoning. It is seldom that the man on duty is unable to advise. On those rare occasions he can turn to the director on call.

Does it work? To apply some criterion to the success or otherwise of such a venture is not easy. Customer demand may afford some measure, and this has remained consistent, even increasing somewhat, over the past eighteen months. A further check is elicited indirectly by the follow-up, every caller subsequently receiving a brief enquiry (and stamped addressed envelope for reply), seeking the details and outcome of each incident. The response averages about 60 to 70 per cent., with a number of unsolicited testimonials and, sometimes, a "rocket." We can conclude that there is a need which we are meeting at least in part.

One further contribution which the follow up affords is on the nature and course of clinical toxicology, particularly of the non-lethal kind. The literature is not lacking with accounts of poisoning and, often, deaths from carbon monoxide, barbiturates and salicylates. What is so much more scanty is information on other forms of poisoning which are less likely to end fatally. At the centre we are accumulating data of this sort, a summary of which has recently been published.* [*Gould.ng, R., Watkin, R. R. (1965) Monthly Bulletin of the Ministry of Health, **24.**]

In brief, children are more often involved than adults; drugs and household products are the principal "niggers in the wood-pile"; poisonous plants, farm chemicals and industrial substances are seldom at fault; *it is the drugs that kill.*

Other Centres. To provide a network throughout the United Kingdom, other official centres have been set up in Edinburgh, Cardiff and Belfast. They are all serviced and co-ordinated from London, and their organisation follows a very similar pattern. The urge to allow these centres to proliferate, as in America, has been resisted. Many of the basic data included in the index are carefully guarded by manufacturers who have been public-spirited enough to entrust them to the service on an understanding of respected confidence. This

would be more difficult to ensure over a multiplicity of centres. Furthermore, despite all the criticism, telephone communications are not all that delayed throughout Britain. London can usually be reached in a matter of minutes; if not, the other three capitals should provide ample reserve. And in general it is probably better to conserve the trained staff at a few centres than to try to employ relatively inexperienced people at numerous others.

Conclusion. This is no comprehensive account of what has been done and what is happening. For this, the official report should be consulted. Rather is this a more personal commentary on how the wheels were put into motion and how they continue to turn. Upon reflection, it is a strange set-up—partly Ministry, partly Hospital and partly Medical School, all without a very clearly defined responsibility. The personnel, too, conform to no systematic plan; they just play their parts, though most of them have other demanding duties. This, at any rate, is an opportunity for paying tribute; first of all to those in authority who were characteristically far-seeing and devoid of insistence on protocol that they allowed the scheme, like Topsy, to grow. Then to the telephonists, renowned at Guy's for their friendliness, helpfulness and efficiency, for their promptness and exemplary resourcefulness at finding particular people on occasion—despite the confusion that can sometimes arise by people saying "Poisons" as though they mean "Appointments". To Matron and to nurses, for whom this has been a new experience, but one in which, though scarcely within the training programme, they have acquitted themselves with distinction. And the anaesthetic registrars, for whom this has been yet a further burden, which they have shouldered with cheerfulness and aplomb. The list could be continued almost indefinitely. The arrangements at all events bear testimony to the value of individual endeavour by contrast to rigid organisation.

The telephone number of the Guy's Poisons Information is HOP 7600, Ext.—Poisons.

CORRESPONDENCE

Marijuana

SIR,—Re your article on marijuana quoted in the *Guardian* on June 1st stating *inter alia* marijuana is less of a menace than alcohol, I would point out that there are as many grades and variations in composition of marijuana as "used increasingly in Britain" as there are in samples of packaged teas. I grew and experimented with marijuana, *Cannabis sativa*, in Africa. You will know that this plant gives products known variously as Indian hemp, dagga (in South Africa, where police action against its use is widespread, especially in Natal), hashish, but you seem to infer that the produce is as uniform as alcohol. The active principle varies very much in the leaves, infloresunas and in the partially developed and seed-bearing female flowers. The partially developed female flowers are the most potent. I would say that smoking dried leaves is less injurious, when smoked in moderation, than smoking the average cigarette of to-day (not the U.S.A. bright tobaccos of yesteryear).

60, Church Street,
Kidlington,
Oxford.

Yours, etc.,

A. WARD HORNBY.

Mr. Slesinger

SIR,—May I through your columns, express my very sincere thanks to all those who attended, or wrote about the parting party given to me on the 9.6.65; also my deep appreciation to all who so generously subscribed to the gift given to me. My heart has always belonged to Guy's, and my sense of loss on retiring from the post of Chairman is greatly lightened by the expressions of affection which have surrounded me. Over the past sixty years I have seen Guy's go from strength to strength, and I am confident that its future will be as great as its past. May I once more say how greatly I appreciate the help and support I have always received from all members of the hospital and schools, and wish them all every success in the future.

Yours, etc.,

E. G. SLESINGER.

47, Upper Brook Street,
Park Lane,
London, W.1,

Mr. Frank Muir's Retirement

SIR,—There has been a good response to my previous letter for a farewell present to Mr. Frank Muir, who retired as chief technician in the Cardiac Department on the 1st April after fifty-three years at Guy's. I feel, however, that there may be some who missed the previous letter who would like to contribute to a leaving present, particularly those who have been house officers or registrars, to whom Mr. Muir was particularly helpful. May I again emphasise that the subscriptions need not be large and that a wide list of subscribers will give the greatest pleasure to Mr. Muir. Contributions should be sent to me at the Warden's House.

Yours, etc.,

CHARLES BAKER.

Guy's Hospital,
London, S.E.1.

Pulse

SIR,—As you mention in Passim (June 12th), *Pulse,* phœnix-like, is about to reappear, and we thank you for your interest; the reason for its "rare appearances" will have been familiar to you before your trans-substantiation to the *Gazette*. *Pulse* and the *Gazette* should be able to fulfil complementary functions.

We cannot, however, agree with your apologia for student apathy—in effect, you appear to be saying "They're not apathetic, they're just disinterested (to the point of apathy.)" The inactivity in evidence among students of this Hospital is the cause of disquiet to many, who are unwilling to believe that the Guy's student—often patently disinterested in his work—is even less interested in the large field of activity once covered by the now-dead societies.

The assumption, nearly implicit in your remarks, was that only the *Gazette* (and perhaps one or two clubs) were really *needed* at Guy's. We venture to suggest that if the *Gazette* supplied only what was actively "demanded" by the students, one would see a very different magazine. If the *Gazette* relied solely upon student contributions, it would be a far, far slimmer publication.

We have not noticed particularly frequent "harangues of the organisers" which you mention, whatever these novel ceremonies might be. Also, despite taking your advice and "looking at the student body through the wooden bars in the Cafeteria", we still feel numb.

As you say, the success of our magazine depends on Guy's students. With their support it should have many years of useful life ahead of it.

Yours, etc.,

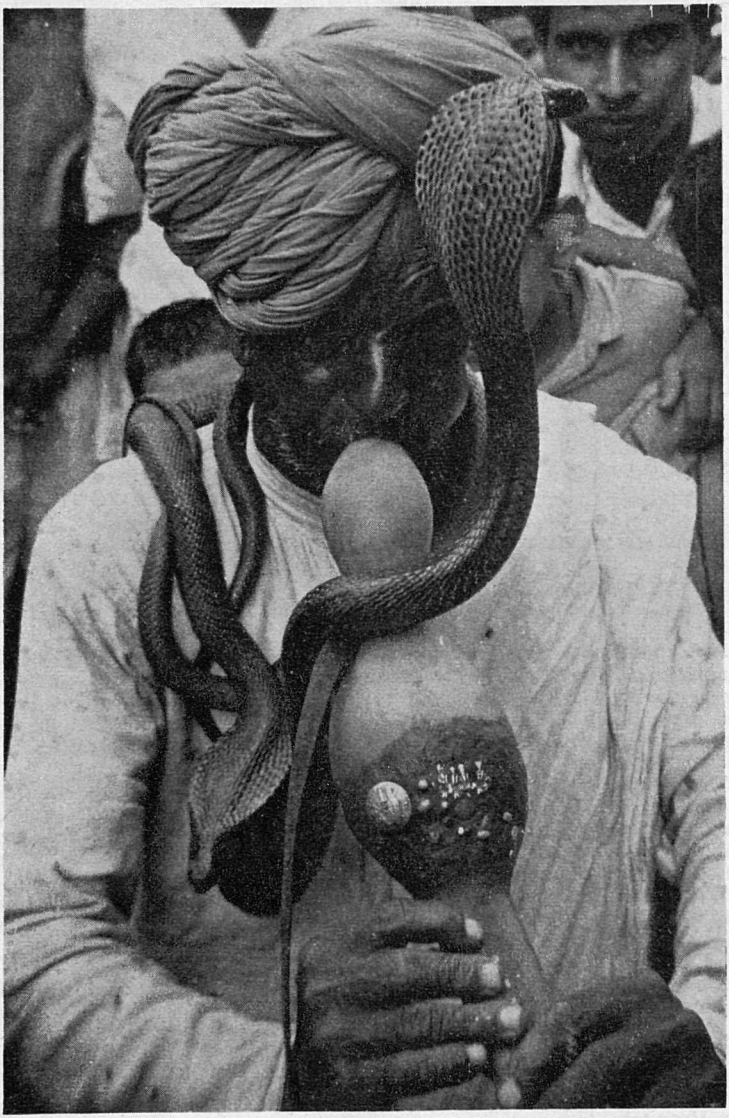
MICHAEL A. SIMPSON (Editor, *Pulse*).

WILLIAM T. C. HUGHES (Business Manager).

Guy's Hospital,
London, S.E.1.

Indian Expedition

by Richard Hughes



SNAKE CHARMER—John Newman

Restless, curious, exam satiated, and conscious of the need to make the most of our last long vacation, four of us organised an expedition to study nutrition in some Indian villages. We left Dover as parochially minded Cambridge examinees. That was June last year. We returned fifteen weeks later, at the beginning of October, wiser for the experience of bumping across Asia and back, and of working with Indian villagers for five weeks. Although this undertaking was hardly conducive to settling readily into the more static life at London teaching hospitals which three of us forthwith began, it expanded our vision of the world and its peoples to an extent which made the fifteen months' preparations for the expedition worthwhile.

Our target was Indore, a large semi-westernised city in central India, 7,000 miles from London, a distance which we covered in five weeks in our green second-hand landrover called Gretna. The roads to India have been enormously improved since the first overland expedition drove from London to Singapore more than ten years ago, but the journey was not without its exciting moments—suspected scorpions by the dozen, a mountain bear in the rocks behind our tents which turned out to be a baby owl grunting from a crevice, Mount Ararat raised on a lava bed above the Turkish plateau, arrest by the Iranian police for photographing a procession carrying the Prophet's shirt, a 300-mile drive along an unmapped Russian road in Afghanistan, and argument with a sacred calf on the road in India. . . . We eventually reached Indore two hours late, and were immediately treated with the magnificent hospitality which was to be ours for five weeks, as we settled down to tea with Dr. B. C. Bose, the Dean of Mahatma Gandhi Memorial Medical College.

Dr. Bose and Dr. M. C. Mittal, the Professor of Social and Preventive Medicine, had nobly prepared the ground for our survey. They had selected areas within 120 miles of Indore suitable for our work and sounded the District Collectors, who provided us not only with accommodation in Rest Houses, but also with as many, or more, peons (servants) than we wanted. Over tea we were introduced to two young doctors, Dr. V. Jandial, who had just won 13 gold medals in his finals, and Dr. A. S. Nagpaul, a bearded Sikh with a splendid turban. These two were to be our interpreters, guides, doctors and companions for the next five weeks, and they were our most valuable asset.

The nutritional survey was originally inspired by Gopalan's records of cases of pellagra among poor people in Hyderabad, further south, who lived chiefly on *jowar*, a kind of millet. Since jowar is rich in nicotinic acid, these records seemed to support the idea that pellagra is caused by an excess of leucine in the diet, and to oppose the currently popular nicotine acid deficiency theory. Kodicek (1962) has shown that nicotinic acid in cereals is bound into an indigestible protein complex, and so the nicotinic acid deficiency theory could still apply even to the pellagrins in Hyderabad. It was therefore of interest to study a population where jowar was the staple cereal, in relation to the intake of nicotinic acid and other dietary constituents and the clinical status of the people.

BASKET MAKER—Ian Waldram

The monsoon decided which villages we should survey, because there were few that we could reach with the landrover, because of the mud and flooded nullahs. Within each village, however, we took a 15 per cent random sample of the households—86 households containing 464 individuals. Our interpreters examined all the individuals for signs of deficiency. We ourselves assessed the dietary intake of each household over a week by weighing the food in the house each day, and then computed the consumption of the different constituents per "consumption unit" for each household: this is a device for comparing one family with another, and involves representing each family as if it was made up of standard adult males instead of men, women and children.

We soon realised that the results of the survey would not help to resolve the pellagra controversy, except to show that this particular jowar diet does not produce pellagra! Therefore we diverted our attentions to obtaining a general picture of the diet and correlating the various factors bearing upon it. We found that 25 per cent of the villagers had at least one physical sign of nutritional deficiency, and 10 per cent had pitting oedema, of which far the commonest cause was presumably nutritional. There was a greater proportion of deficient individuals in the poorer than the richer households, and in the lower than the higher castes. Nevertheless, the mean calorie consumption per consumption unit per day was $3{,}200 \pm 1{,}300$, and the mean protein (virtually all vegetable protein) consumption per day was 107 ± 42. The richer people ate more than the poorer, and the higher castes more than the lower: there is an approximate correspondence between the position of each family on the income and the caste scales. These figures mean that a quarter of the villagers have a mild generalised deficiency, rather than a lack of one particular

factor, in spite of the fact that their diet superficially appears adequate. Lest this statement should detract from the forceful impact of Freedom from Hunger advertisements, it should be pointed out that these villages lay in the comparatively rich and fertile central part of India, and had not suffered from the succession of crop failures which caused famine in other States.

We hope that our report may help jog the local powers-that-be into doing something about improving the villagers' diet. It became clear during the survey that almost no vegetables are eaten, although they grow very readily; virtually no animal protein is eaten; the protein in the diet is mostly derived from the jowar. It is curious that the villager should grow beans and gourds for sale in the town, and yet scarcely eat any himself. A very effective, rapid and cheap way of improving the diet would be to encourage the use of whole groundnuts for cooking. At present, large quantities are grown, but they are almost exclusively used for making cooking oil: the protein is extracted, and either made into cattle fodder, or thrown away. If plant could be installed at each oil factory for making a protein rich meal from the groundnut residue, this valuable source of protein need not be wasted. Simply by preserving the protein residue, or by cooking the groundnuts whole, the quality of the protein in the villagers' diet could be enormously improved. The survey, therefore, indicated several specific ways in which the villagers' food could readily and inexpensively be improved.

This was not the only work we undertook. In one of the seven villages in which we worked, we performed a detailed sociological study and throughout the district we visited we reviewed the possible openings for Voluntary Service Overseas workers for a report to the Department of Technical Co-operation. The value of the expedition lay not only in the results of the various projects, but also in the education it gave to us, to our interpreters, to the Indian medical students we met in Indore, the people we met by the road, and the unfortunates in England who listen to, or read, our travellers' tales. Although the journey itself was too rapid to allow us to ponder and muse on the strange sights and customs of the middle, and not so middle east, it is incomparably preferable to have even the briefest mental picture of the mosques of Istanbul, Baalbek's shattered visage of Rome's empire, and the ragged Afghan villagers scurrying round their hay-rick beds to find us a safe camping place—it is better to have glimpsed these things, than to watch Topkapi, study Tacitus' terse Annals, or read Thesiger's exploits in the Arabian desert. The journey's glimpses brought the *world* to life before our eyes, and will yet enliven many a dusty page of the books we have still to read.

Between the rush of reaching India, and the race back to England, came five weeks in the Indian villages, five weeks of tremendous experience, which taught us how utterly differently different people live. This was the real India which we were seeing—not the charming and educate few who we meet in England and who live abroad or in the really big cities, not the holy men from Kipling, the romance of "A passage to India", nor the excitement of John Masters' novels,

but the villagers loafing and toiling on the land by turns day after day. We had to understand the workings of the village and the households to conduct our survey. They are Hindus mostly, although in each village there are one or two Moslems, who live peacefully, somewhat apart, but no more than one Hindu caste is from another. Religious differences between the castes are no longer as sharp as they used to be, but religious customs still dominate the village life. Marriages, which are arranged by the parents and take place between about 7 and 16 years of age, are only possible between two members of the same caste. A further restriction prevents marriage within the same village, and thus reduces the risk of in-breeding, which intra-caste marriages would seem to encourage. Their diet, too, is controlled by religious ritual. The higher the caste, the more things are taboo. While the out-caste will eat anything he can get, the Brahmin, the highest caste, will eat no meat, fish or eggs, because they are deemed polluting. A Brahmin will not accept any sort of food from a lower caste lest he be polluted by contact with the lower caste. What is not controlled by religion is controlled by the weather and soil, until weather, soil and religion seem one—a civilisation with such different materials and philosophy from our own that we were fascinated. The more inquisitive we became and the more questions we asked, the more responsive were the villagers, and despite the language-interpreter block we each made several friends, so that it was a sad time when we had to leave.

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Kodicek, E. (1962). *Nutritio et Dieta*, 4, 109-127. Karger, Basel/New York.

Fuller details of the expedition are contained in the Report, copies of which may be obtained from R. A. C. Hughes or J. H. Newman, East Wing, Guy's Hospital Medical School.

DR. FLEETWOOD STIRLING DIGBY BERRY

On Saturday, 29th May, Dr. F. S. D. Berry, an old Guy's man, died in Johannesburg. He had been in poor health for a few years and he died one week after his 79th birthday. Dr. Berry, the son of a clergyman, was born in Melbourne, Australia. He was educated at the Melbourne Grammar School and then proceeded to Guy's Hospital, where he qualified in 1909. In 1910 he came to South Africa and started in general practice in Johannesburg, which was then little more than a mining camp and had more than its fair share of adventurers and criminals, who made general practice, on occasion, hazardous.

During 1914, Dr. Berry was involved in the notorious "Foster Gang" affair, and his bravery in assisting the police on that occasion is still talked about in Johannesburg to-day. During the First World War Dr. Berry served with the South African Forces under the late General Smuts in East Africa. He resumed his practice after the war. Dr. Berry was a Life Member of the South African Medical Association. He is survived by his widow, two sons, one an engineer and one a doctor, and two daughters. We express our deepest sympathy to them all.

BIRDS OF SCILLY

by

David Healey

Expanded on the sea and encompassed by the relentless Atlantic waves are the Isles of Scilly, the Archipelago which lies twenty-eight miles west-south-west of Lands End, consisting of five inhabited and many more uninhabited islands and rocks.

St. Agnes, where the bird observatory is situated, is the most south-westerly island in Britain. To the west of it lies Annet, the Western Rocks and the Bishop Rock lighthouse. To the north and north-east are the other islands. Its coastline of granite boulders is broken at some parts to form beaches which lead down to extensive beds of seaweed at low tide. The south of the island is downland, and the north-west portion possesses open fields and a fresh water pond surrounded by reed beds. The rest of the island has a small wood of stunted oak, white-washed cottages containing the population of fifty, and a maze of tamarisk and dense escallonia hedges which shelter the small bulb fields. Another much smaller island, Gugh, connected to the east of St. Agnes by a sand bar, is mostly covered by bracken, red and white heather, where in late August myriads of Painted Ladies, Red Admirals, Greater Fritillaries and Clouded Yellows feed on their migration. To where?

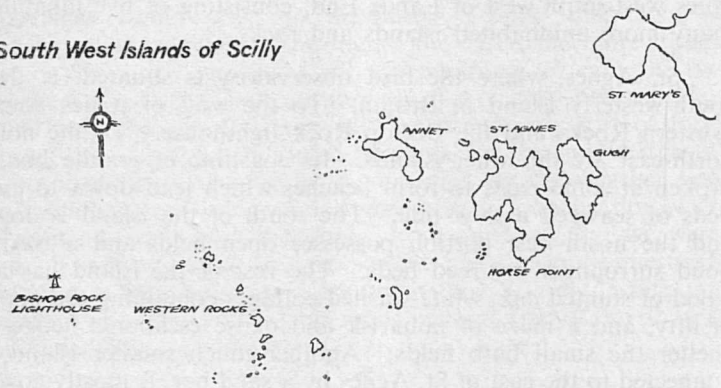
The Isles of Scilly are isolated and are therefore a haven for tired and hungry birds. Their southerly position makes a convenient setting-off point for the Continent; the latitude is the same as Dieppe and North Luxembourg. St. Agnes itself is the most ideal island for observing migration. It has the wide variety of habitat already described and can be covered with ease each day. It is the most likely island on which to see vagrant American birds, and Horse Point, its most southerly protuberance, is a sea-bird watching point. The light-house on Bishop Rock has a profound effect on birds, for during September a large number of new migrants were first seen at 10 a.m. These night migrants were attracted by the powerful light and settled on the nearest available land to it, that of the Western Rocks and Annet and at daybreak made their way to the nearest island of plentiful food supply, at St. Agnes, where they joined their earlier feeding, already settled companions.

Migration takes place regularly and periodically each year; in autumn there is a general movement south. Common species would be present on many days at this time of year. Swallows, Willow Warblers, Chiffchaffs, Pied and Spotted Flycatchers were present on the island from August 16th—September 26th. Peak numbers of a species usually occur after certain weather conditions in that period

of autumn when the bulk of them pass through Britain. For many of the passerines (perchers, comprising the great mass of small land birds) this period is the end of August and the first half of September. Two factors concerning weather usually ensured influxes of passerines. Poor visibility at night brought down most migrants, which would have otherwise flown on. The direction of wind determined their arrival.

Easterlies or south-easterlies are inclined to drift the mass of birds crossing Northern Europe westwards. In these conditions Scilly could receive birds from any of the following main streams:—

The South West Islands of Scilly



(1) General movement, but comparatively scattered, over the British Isles.

(2) A concentrated stream down the East Coast of Britain from Shetland to Kent.

(3) The above stream is joined by a passage across the North Sea from Scandinavia, taking the form of a broad front.

(4) At Kent the above two are joined by one that has come down the western coast of Denmark, Germany and the Low Countries.

(5) A separate stream composed of Shetland and Orkney birds and some from the Faeroes and Iceland, which cross westwards across the top of Scotland and through the Irish Sea. Scilly would receive migrants from this stream without the aid of east winds. Evidence of drift was observed on August 21st after a day of easterlies:—22 Pied Flycatchers, 23 Spotted Flycatchers, 50 Willow Warblers and 50 Chiffchaffs were present on the island. On September 3rd, after five days of south-easterly winds, an influx of 60 Pied Flycatchers, 20 Spotted Flycatchers, 20 Yellow Wagtails and 12 Willow Warblers occurred. Whereas on September 6th, after two days of westerly winds, only 3 Pied Flycatchers, 2 Chiffchaffs and 4 Willow Warblers were present.

The concept of drift might seem difficult to accept when one considers ringed Swallows who arrive at almost the same date each year at their nesting barn but it is known that birds can correct their

lateral displacement to an amazing degree of accuracy. An example of this phenomena was that of a Manx Shearwater with young on Sholholm, an island off the south coast of Wales, which was taken by air to Hungary and set free. In three days it had arrived back at the nest, having travelled a distance of 1,100 miles over unfamiliar land. Large lateral displacements occur in nature for Eastern Europe and Asian species frequently occur in our islands. On September 6th, a Greenish Warbler was identified on St. Agnes. The species' breeding range extends as far west as Poland but migrate normally to winter in Asia; a displacement of at least 900 miles.

South and south-east winds bring those birds whose breeding range only extends as far north as Spain and France often northwards, especially young birds. Such was the case on September 2nd, when 3 Melodious and 3 Icterine Warblers were identified mostly young for the time of year, and on August 26th with an Immature Woodchat Shrike after a day of southerlies. These cases support to a certain extent the theory of Extra-Juvenile dispersal which proposes that the migratory instinct is strongest in the young and being inexperienced they are more inclined to incorrect orientation by opposing winds; a method, no doubt, of a species extending its breeding range.

With westerly winds, influxes of Meadow Pipits and White Wagtails often occurred since there is a large stream of these migrants passing down the West Coast of Ireland from West Scotland, Faeroes, Iceland and Greenland. The presence of American birds in Scilly has already been mentioned and in fact an average of six birds of varying species are seen each year. On the evening of September 21st, St. Agnes suffered a strange upheaval of the sea, without any apparent wind. This was the wash of hurricane Dora, which had produced south-west gales in the Atlantic. Next day the American White-Rumped Sandpiper was found on a beach facing the Bishop Rock, having probably completed a non-stop journey of at least 2,400 miles. Local strong westerlies brought passing southward moving sea-birds into closer view of Horse Point and on days when sea foam was flung up the rocks, tearful eyes saw Shearwaters, Skuas, Fulmars, Gannets and Grey Phalaropes. In 1960, after many days of these conditions, *c.* 2,500 Grey Phalaropes flocked off the point. This bird, eight inches long, breeds in the Arctic and sub-Arctic zone and in winter flocks in mid-Atlantic on both sides of the Equator. Last Autumn, in the absence of such conditions, only one was seen, on September 16th, after a day of gales.

All movement is not seasonal migration. Pelagic sea-birds make vast dispersive journeys throughout the year to suitable feeding grounds. Gannets, often 100 in an hour, were seen consistently, close inshore. Ringing of breeding Manx Shearwaters on Annet, the largest breeding colony in the British Isles, has shown that adults with mates on eggs may travel as far south as the Spanish coast, a distance of 1,000 miles there and back, to feed on sardines (they are shot by the sardine fishermen). Allowing for feeding time, this could be accomplished in two days. Shearwaters were never seen about

the islands during the day or on moonlit nights as they are the main prey of the Greater Black-Backed Gulls, but on some August evenings they were seen shearing in the troughs of waves to rafts off Annet, where they would wait until darkness to feed their young. The wings of the Gannet, Fulmar and Shearwater are comparatively long, but narrow and tapering, and they use this adaptation in gliding and thus reducing energy. Forty feet above the surface of the sea, the wind often blows as fast again as it does at sea level, where it is slowed down by the drag of the waves. Good use is made of this speed gradient or "wind shear"; gaining momentum rapidly as the bird descends from faster to slower moving layers, and lift from the reverse movement. The latter is but one of so many methods by which birds have used the forces of the elements to save their own energy and from which we have learnt so much.

That birds can be drifted off their normal course and that they can correct their displacement, points to the fact that known geographical landscape is not the only "signpost" to their destination. Some men have put forward the theory that they pilot by the stars and sun or can even interpret the differing magnetic fields on the earth surface. The complexity of the subject is its mystery and long may it remain so.

REVIEW

THE SURGEON'S CRAFT

by Hedley Atkins, D.M., M.Ch., F.R.C.S., Professor of Surgery, University of London at Guy's Hospital.

This book is one of a series on professional crafts, and is mainly intended for the lay public. The Historian's Craft has already appeared, The Geographer's Craft is in preparation, and The Mathematician's Craft is contemplated. The proceeds on the sale are to be assigned to the preservation of Down House, as a memorial to Charles Darwin.

It is always very difficult for a medical man to write for the lay public, and on the whole Professor Atkins has achieved this admirably. He relates in brief the history of surgery back to 1500 B.C. He then defines those qualities that a surgeon needs, followed by a chapter on the surgeon's daily task. We then find details of professional examinations required and of the rewards that may be anticipated. This chapter, in my opinion, goes into unnecessary detail, unless the author is aiming his remarks at careers masters and schoolboys who may read the book. But of course today the wages of doctors are matters for public discussion.

The book closes with chapters on " the advancing edge", and on surgical colleges, societies and committees which may obtrude into a surgeon's life. It is in fact an excellent review of a complex profession, written, as one might expect, in impeccable style.

MR. N. L. ECKHOFF.

First Aid Lectures

Lieutenant General Sir Alexander Drummond will give a course of First Aid Lectures to the Pre-Clinical Course in conjunction with Mr. P. Clarkson, Mr. R. Beard and Mr. W. Crabbe. There will be an examination at the end of the course, and those who attend the lectures and pass the examination will be eligible for a certificate.

SPORT

CRICKET

For the third year in succession, a Guy's team capable of winning the Cup, has been knocked out, this time by St. Bartholomew's Hospital. They owe their victory to their opening bowlers, who were able to exploit a tricky wicket to dismiss Guy's for the inadequate total of 165, and to two middle order batsmen who cashed in on missed chances and slowly accumulated 80 runs between them to give their side a four-wicket victory.

This match apart, the Guy's team has performed well, and some exciting games have been played. Two fine wins were recorded, one against Hampstead, who had two County players in their side, and the other against Dulwich Hamlet, in which our 2nd XI off-break bowler Steer, playing for the 1st XI, took 9 wickets.

In the Past v. Present match, a very fair declaration by the Present gave the Past equal time to make the runs, which they did two minutes before time.

The highest score, made by the Guy's side this season, was at the Neville County ground, Tunbridge Wells, when Guy's declared at 263 for 6, Appleby having made a fine unbeaten 79. The game was drawn, the Madhatters losing 9 wickets in scoring 220. A fine game of cricket played in perfect conditions.

ATHLETIC CLUB

Guy's will be defending the Inter-Hospitals Athletic Title at Motspur Park on Saturday, July 3rd. The programme includes the Consultants' Handicap walk, with Dr. Roger Bannister starting from scratch, and also the Inter-Hospitals Tug-of-War with a strong Guy's team coached by Mr. Tomkinson bidding for a second successive victory. It is hoped that as many members of the hospital as possible will come down to give support.

CRICKET

2nd ROUND HOSPITALS CUP.

GUY'S v. BARTHOLOMEW'S HOSPITAL.

On Thursday, 17th June. At H.O.P.

Result: Guy's lost by 4 wickets.

Guy's lost the toss and were put in to bat on a drying wicket. Good spells by the Barts. opening bowlers, both left-armers, sent back McGregor, Cutler and Hambleton, and when Butchey was run out, the score board read 12 for 4. Fortunately, Powell-Jackson and Mike Jones came to the rescue and took the score to 99 without further loss by lunch time. After lunch the conditions had eased somewhat, but Jones, who had made an excellent 50, was soon bowled. Powell-Jackson went on to make his half-century, and Crafts fought hard for an unbeaten 21. Guy's were finally all out for 165.

In the session before tea, Barts. replied with a confident 35 without losing a wicket. However, after the interval, Knott and Davoodbhoy broke through and took 4 quick wickets with the score only having reached 56. Later the score was 97 for 6, but then Delaney (53 not out) and Berstock (30 not out), after shaky starts, batted intelligently and steered their side to victory, though not without giving two vital chances in the field which were missed! A marked contrast to the excellent catching earlier in the innings, particularly by Mike Jones.

Thus for the third year in succession, Guy's have been unexpectedly knocked out of the Cup—most disappointing, but the best of luck, Barts.!

Scores: Guy's 165 (Jones M. 50, Powell-Jackson 50, Crafts 21*, Savage 5 for 67, Vartan 3 for 40).

Barts. 167 for 6 (Delaney 53*, Berstock 30*, Davoodbhoy 4 for 60, Knott 2 for 49).

PAST v. PRESENT.

On Saturday, 12th June. At H.O.P.

Result: Past won by 3 wickets.

A run spree by Butchey, McGregor, Cutler and Silk enabled the Present to make a half-time declaration. Knott, perhaps a trifle unlucky, did not take any wickets—perhaps he was showing loyalty to the Present, for whom he usually plays. His allegiance went even further, when he opened the innings for the Past and "gave up" his wicket first ball to his stand-in opening bowler. Then Mike Jones joined Myall and these two took the score to 123 before the stand was broken—an excellent partnership. Wickets then fell fairly regularly to Davies and Davoodbhoy, but each batsman contributed a few, Lam more than most, scoring a useful 25, including two big sixes. When Proctor, our 2nd XI captain, joined Mr. Glover, these two scored the remaining 15 runs competently, Proctor hitting the winning six two minutes before time.

Scores: Guy's Present 193 for 4 (Butchey 65, McGregor 27, Cutler 33, Silk 30*, Banks 3 for 63).

Guy's Past 195 for 7 (Myall 60, Jones M. 57, W. Davies 4 for 56).

GUY'S v. DULWICH HAMLET.

At H.O.P. 13th June, 1965.

Result: Guys won by 2 runs.

Jo Butchey and Mike Jones, making his first appearance for the 1st XI this season (after qualifying, marrying, etc.), made the

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Hamlet bowling look deceptively easy. When their partnership of 70 was broken, the remainder of the batting had a casual air, and when the groundsman started the engine of his motor roller at a quarter to five to the indignation of numbers 10 and 11 batsmen, he was regrettably not kept waiting long to roll the pitch.

Thus Dulwich Hamlet were left too much time to score too few runs. When they had 80 for 0 and only 70 were needed in the last hour, the result seemed inevitable. However, in an incredible hour the pendulum swung the other way, and Steer, the 2nd XI off-break bowler, aided by some magnificent catching, performed the astonishing feat of taking 9 wickets for 31—a fine spell that won Guy's the match.

Scores: Guy's 153 (M. Jones 70, J. Butchey 37).

Dulwich Hamlet 151 (D. Steer 9 for 31).

J. K. Crafts.

GUY'S v. THE MADHATTERS.

Away. 20th June, 1965.

Result: Draw.

On a glorious sunny day at the picturesque Neville Ground, Tunbridge Wells, Guy's won the toss and elected to bat first. The wicket was very hard and dusty and the morning's play was dominated by a very good 48 by Butchey. Four wickets were lost, however, one to the last ball before lunch, which was taken after 90 minutes' play with the Hospital at 101 for 4.

After lunch the score was increased by 52 in 40 minutes for the loss of Powell-Jackson for a good 34 and Reekie for 20. Appleby was then joined by Steer, and these two proceeded to add 110 in 50 minutes before Guy's declared at 263 for 6 wickets, taken off 57 overs. Appleby, after a slightly shaky start, was undefeated at the end with 79, including 2 sixes and 13 fours.

Craft's declaration at 4.0 p.m. left the Madhatters with exactly equal time. However, it was soon apparent that they were going to find it difficult to score the runs. The 50 minutes before tea was spent in collecting 32 runs for the loss of 1 wicket. Butchey began a long spell of bowling and bowled 23 overs tidily. The Madhatters were unable to score sufficiently quickly, and with 45 minutes to go the score was 140 for 4 wickets. The match seemed doomed to be drawn. However, the last 45 minutes were very entertaining, 80 runs being scored by the opposition, but Guy's captured five more wickets and must surely have won but for a number of dropped catches. The Madhatters finished with 220 for 9 wickets.

Scores: Guy's 263 for 6 dec. (Appleby 79*, Butchey 48, Powell-Jackson 34, Steer 33*).

Madhatters 220 for 9 (Crafts 3 for 18, Butchey 2 for 82, Steer 2 for 29).

GUY'S v. HAMPSTEAD.

At Hampstead. Sunday, 6th June.

Result: Guy's won by 96 runs.

With the memory of last year's defeat still uncomfortably fresh, Guy's were none too confident against the club who as usual contained a fair sprinkling of Blues, Foresters and even the odd ex-Guy's man. The day and the setting were perfect, and so it was with some sense of achievement that the captain informed his team that they were batting. Runs did not come quickly against the opening attack. When Gooneseena came on to bowl his leg breaks, the scoring rate dropped even lower, and wickets fell as the early batsmen attempted to seek a rash remedy to the dearth of runs. Silk batted most sensibly and it was largely due to him that Guy's were able to eat lunch knowing that 68 for 3 was on the board.

After the interval he continued in much the same fashion and laid the foundation for the later batsmen. Of these mention must be made of Knott's contribution and the value of having such a talented No. 9. Guy's were eventually all out just before tea, having amassed 166 runs. The quarter-of-an-hour before tea was perhaps the most vital part of the match, because in this time four of the Hampstead batsmen were returned to the pavilion for only 8 runs. Only two of their batsmen offered any real resistance. One of these Butchey bowled round his legs, having been previously struck for 3 consecutive boundaries. Hampstead were finally all out for 70 to complete a most satisfactory day's cricket and sweet retribution for the previous year.

Scores: Guy's 166 (Silk 35, Powell-Jackson 24, Knott 30, Gooneseena 5 for 53).

Hampstead 70 (Knott 3 for 23, Beacham 2 for 20, Davoodbhoy 2 for 8, Butchey 3 for 19).

J. Powell-Jackson.

ATHLETIC CLUB

GUY'S v. WESTMINSTER

At Cobham June 16th, 1965

Result—won.

This match, which was held on a wet and dull afternoon, resulted in a resounding win for Guy's, with first place in every event! Performances were of a very high standard considering the conditions—the best effort of the afternoon coming from Ian Morgan, who ran the 440 yards in 49.8 secs., which was 0.4 secs. better than his previous best. Andrew Winskill ran one of his best ever races to record 15.4 secs. in the high hurdles, and Richard Quinnell produced a personal best shot-put of 39ft. 11ins. J. Wheeler won the mile easily in 4mins. 38 secs., and then went on to win a closely contested 880 yards, in which Ian Morgan set the early pace, in 2 mins. 3 secs. Don Barford began his afternoon with a rather casual win in the 100, and then went on to win the 220 in 23.3 secs. Other winners were J. Domaingne in the Long Jump, with 20ft. 1in.; Barry Hartley in the Javelin; Richard Morris in the High Jump, with 6ft. 1in.; and Richard Quinnell in the Discus. An efficient afternoon's team work was completed with an easy win in the 4 x 110 yards relay.

BOAT CLUB

U.H. Bumping Races, 1965

The U.H. Bumping races were held on 24th, 25th, and 26th May, at Chiswick.

On the first night, the first eight had a very bad start and were quickly caught by Westminster Hospital, and by the second night Guy's had a much better row, but could not get back on terms with Westminster. On the third night, Guy's went off to a very good start, got up with Westminster quickly, but could not quite find enough pace to bump them.

The Second eight rowed over all three nights without changing position. The first eight now lies fifth.

Unfortunately, the first eight coxswain, A. Green, was taken ill just before the races and A. Pickering took his place.

The Boat Club A.G.M. will be held at 1.00 p.m. in Anatomy Theatre, on Wednesday, 30th June.

GOLF CLUB

Annual Open Day, 1965

At Knole Park G.C., Sevenoaks. May 29th.

The Annual Open Day was held this year at Knole Park G.C., Sevenoaks. This was the second visit to Knole this year, and many had gained a little local knowledge.

The morning round was a Fourball Bogey competition, and M. Pagliero and B. Bevan Jones had things very much their own way to take the Prize and Sweep four up.

The main competition of the day was a Stableford Foursome in the afternoon. The results were very even, and in spite of Dr. Maclean and P. Ellis playing their ball from underwater to draw on the 18th green with Dr. Cole and M. Brummitt, the eventual winners, with 34 points, were Mr. Lane and A. Phillips. Mr. Brain and B. Bevan Jones came second.

The winners took away a golf umbrella and a putter; we hope they don't have to use them too much.

Twenty-two players took part in the afternoon round, and all of them will be glad to know that the club has offered to play host to us again next year when, it is hoped, even more of our members will be able to join us.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL AND THE SOUTH-EAST METROPOLITAN REGIONAL HOSPITAL BOARD

Applications are invited to fill an established vacancy as **Senior Registrar in General Medicine to the Board of Governors of Guy's Hospital and the South-East Metropolitan Regional Hospital Board.** Applicants will be expected to spend one year in the region during a two-year tenure of the post. The appointment will be made jointly by the bodies concerned. The post, in the Regional Hospital, will be held in the Bromley Group. The post, which will be reviewed at the end of the first year, is subject to the Terms and Conditions of Service of Hospital Medical and Dental Staff (England Wales) with duties commencing 1st October, 1965. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, S.E.1., not later than **30th June, 1965.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **middle-grade Registrar in Anaesthetics,** for a period of one year from 1st October, 1965. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, S.E.1., not later than **30th June, 1965.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the appointment of **locum middle-grade Medical Registrar,** for the period 11th August to 30th September, 1965. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, S.E.1., not later than **6th July, 1965.**

GUY'S HOSPITAL MEDICAL SCHOOL, S.E.1.

Applications are invited for the posts of one **full-time Junior Lecturer in the Anatomy Department,** and one **part-time Junior Lecturer in the Anatomy Department** to be combined with the post of **part-time Assistant to the Director of the Student Health Service.** Forms of application are obtainable from, and should be lodged with, the Dean, Guy's Hospital Medical School, S.E.1., not later than 10th **July, 1965.**

THE ROYAL MARSDEN HOSPITAL, SURREY BRANCH, DOWNS ROAD, SUTTON, SURREY.

Appications are invited for the post of Resident Senior House Officer. This is a Post-Graduate Teaching Hospital, a radiotherapy centre with high energy apparatus and 99 beds. The appointment will be for one year. Application forms can be obtained from the Administrator, to whom they should be returned as soon as possible.

PASS LISTS

SOCIETY OF APOTHECARIES OF LONDON

Final Examination, May, 1965

Pathology and Bacteriology

M. A. Q. Jamil

Midwifery

M. A. Q. Jamil N. W. D. Walshaw

NURSING NEWS

Entered

Sister R. Pritchard to York Clinic.
Sister H. Smith to Nuffield House, Night Duty.

PERSONAL

LONDON, S.W.7. Lock-up practice in busy expanding shopping area. Two fully equipped surgeries, waiting-room, darkroom, etc. Good private nucleus. Eight year lease, £300 p.a. inclusive, £3,250 o.n.o. No terms. Box No. 12.

DENTAL PRACTICE FOR SALE.

TEN-ROOMED house with surgery and waiting room accommodation (60 years lease) in Dulwich. Small nucleus capable of rapid expansion. Purchase out of income. Box No. 13.

BIRTHS

BLAKE: On May 29th, 1965, at Cuckfield Hospital, Sussex, to Katharine (nee Cuthbert, M.R.C.P. Ed.) and Henry Blake, M.B., B.S., of 2, Houndean Rise, Lewes, Sussex, a son (Ian Henry).

GAIN: On June 14th, 1965, to Dr. and Mrs. Robin Gain, of 34, Devereux Drive, Watford, Herts, a daughter, Sally Christine, a sister for Richard, Andrew and Judith.

MARRIAGES

SCOTT-KERR—MARTIN. On March 27th, 1965, at Nelson, B.C. Canada, Michael Scott-Kerr, M.B., B.Chir., to Eleanor Martin, R.N.

CHANGES OF ADDRESS

Dr. M. T. Scott-Kerr, M.B., B.Chir., to 350, Albert Street, Namaimo, B.C., Canada.

T. Glyn Thomas, F.R.C.S., to "Manyara", Bushy Ruff, Dover. Tel: Kearsney 2321.

G. A. R. Winston, Esq., to 5, Arthur Bliss House, Finches Gardens, Lindfield, Sussex.

L. Wynn Houghton, F.R.C.S., Radlett Cottage, Spaxton, Bridgewater, Somerset. Tel. No. Spaxton 362.

GUY'S HOSPITAL GAZETTE

FORTNIGHTLY ONE SHILLING VOLUME 79 NUMBER 2008

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EDITORS P. BOWDEN AND A. E. RAYNES

SPORTS CORRESPONDENT A. PROCTER

GUY'S HOSPITAL, LONDON

PASSIM

Sir Russell Brock

In the last issue of the *Gazette* we mentioned the great distinction to be bestowed on Sir Russell Brock by Her Majesty the Queen. He qualified in 1926 and on receiving his degrees was awarded honours in Anatomy, Medicine and Surgery. Fellowship followed in 1928 and Mastership in 1932. His considerable contribution to Thoracic and, in particular, Cardiac Surgery has gained for him a unique place in his profession and brought honour to Guy's. In July 1954, the distinction of Knighthood was conferred on him and more recently he became President of the Royal College of Surgeons. We offer him our sincere congratulations and may his example continue to be a source of inspiration both to his colleagues and to the hospital.

A Matter of Opinion

It has been one of the physical phenomena of the voices of student opinion at Guys that they rarely echo beyond the walls of the Spit or bar. The recent meeting of the Student Education Committee, with Dr. Houston and Dr Trounce, to discuss a preliminary survey of student opinion on education, is reported in this issue of the *Gazette*. This student committee has in its short existence engineered a platform for staff-student communication. The value of this contact will be in its approach to the pattern of academic weaknesses of students which reflect deficiencies in the method of education. The interest of the staff in this committee is a recognition of the value of student opinion in the design of his own education.

The Royal Commission on medical education, appointed almost as late as the system is out of date, might do well to acknowledge this principle. A task of the Commission will be to define the medical requirements of the community and to tailor a system of education to produce doctors to suit these demands. The student, therefore, will be the instrument with which a new health service is moulded. His opinion should be heard. It would be an enlightened step and at least democratic if the British Medical Students' Association be represented in this commission.

Dr. Thomas Glyn Thomas, F.R.C.S., has been appointed Consultant Orthopaedic Surgeon to the South East Kent and Isle of Thanet Group of Hospitals.

Dr. Ronald MacKeith has been appointed an honorary member of the Catalan Paediatric Society.

Dr. Charles Gallagher, Principal Medical Officer of the Regional Medical Service, Ministry of Health, has been awarded a C.B.E. in the recent Birthday Honours.

Paper Backed

As knowledge changes so do the methods by which we acquire it, and unless we require a work of reference we no longer have great tomes which look learned on a book shelf and are bound to last a lifetime, solid stuff. They have been replaced by the paper-back, a revolutionary medium, cheap, changeable with the times and not meant to last. The warning that "this textbook is not to be used as a substitute for the more complete texts and reference works but as a supplement to them" or that "the authors realise that the concise format used tends towards over-simplification and dogmatism" goes unheeded and many a Pocket Edition becomes the only edition.

Even contents differ. The text is serialised, sub-divided and categorised so that even the most obtuse may glean something from it all, pages of explanation and discussion are replaced by a line drawing whose clarity stuns. They present pictorially the meat of the problem without the garnish of "ifs" and "buts". They represent the common places in which common things commonly occur and the abundance of abbreviations is bewildering to the uninitiated.

Quote from the *Lancet*, "The rapid expansion of medicine has brought the danger that its students, in becoming more and more learned, may become less and less civilised."

Erratum

Dr. J. Fraser Roberts, C.B.E., F.R.S., is Geneticist to the Paediatric Research Unit and Honorary Clinical Geneticist to Guy's Hospital.

GUY'S DIARY

JULY		
Exhibition.		*Conjoined Twins.*
12th M.	1.00	Mr. TOMKINSON. Clinical Lecture. *"Problems in the Puerperium."*
13th T.	1.00	Dr. WAYTE - Clinical Lecture
15th Th.	1.00	Mr. WASS. Clinical Lecture. *"Swellings in the Scrotum."*
15th Th.	5.00	Neurosurgical Round conducted by Mr. Murray Falconer. in the Clinical Theatre.
16th F.	1.00	Dr. KAUNTZE. Clinical Lecture. *"Dyspnoea."*
19th M.	1.00	Dr. R. W. Te. LINDE. M.D., Emeritus Professor of Gynecology, John Hopkins Hospital, Baltimore, U.S.A. Clinical Lecture. Subject: *"The Carcinoma In Situ Story"*
20th T.	1.00	Mr. ECKHOFF. Clinical Lecture. *"Cleft Lip and Palate."*
22nd Th.	1.00	Mr. BLACKBURN. Clinical Lecture. *"Goitre"*
23rd F.	1.00	Dr. MacLEAN. Clinical Lecture. *"Recent Advances in Medical Treatment."*
24th S.	10.00	Clinico-Pathological Meeting, held in the Clinical Theatre.
30th F.	1.00	Dr. SCOTT. Clinical Lecture.

A CLINICAL VIEW OF GENETIC RESEARCH

by M. E. Pembrey

WINNER OF THE LAIDLAW PRIZE, 1965

The science of genetics is a relatively recent and rapidly expanding field of research; and research of necessity precedes any clinical application. Yet on investigation, there is a singular lack of any attempt in the literature, to relate the two; to explain the classical concepts of a dominant, recessive and sex-linked condition in terms of recent biochemical theories of gene expression. The reason for this is probably that there is no simple explanation; that the mass of facts obtained from observations in bacteria to abnormal haemoglobins cannot yet be synthesised into a simple concept of gene action, that is applicable to man. The reason why this link between genetics and medicine has been difficult to establish becomes apparent when one considers what I have called "a spectrum of genetic expression". Such general views of genetics are not new, but I hope by emphasising this spectrum that some of the stumbling blocks in the synthesis of clinical concepts into genetics will be removed.

"A spectrum of genetic expression".

D.N.A. and Histones		Primary Proteins	Secondary Proteins		Cell Metabolism
1		2			3
Cell Differentiation and Tissue Form		People and Peas	Families		Races
4		5			6

There are certain points on the spectrum where genetic research appears to have concentrated. Mendal worked with his peas at point 5, and subsequently a vast amount of work on pedigrees has been done, much from direct clinical observation. Much recent research has concentrated on the extreme left of the spectrum, sections 1 and 2, whilst in section 4, the genetic control of cellular differentiation and tissue form is only just beginning to be systematically investigated. Waddington has done much to organise the problems involved in his recent book, "New patterns in genetics and development". It is this relatively unexplored field separating the clinical genetics from the mass of genetic research that has made it so difficult to express classical genetics in terms of recent biochemical theories of genetic expression.

To consider parts of the spectrum in detail will be of some value.

Section 1. This is an immense field of research, the work of Watson and Crick being prominent.

Section 2. Much of the research here has been done on bacteria and to some extent in abnormal haemoglobins. From this has arisen Morod and Jacobs' "Operon Theory".

Section 3. This has to some extent been linked to clinical medicine. Outstanding was Archibald Garrod's work on alcaptonuria, resulting in the concept of "inborn errors of metabolism" as a cause for certain clinical syndromes. More recently Beadle and Tatum, working with bacteria, have formulated the theory of "One gene—one enzyme". This has been somewhat modified in recent years, but its essential correctness remains unchallenged.

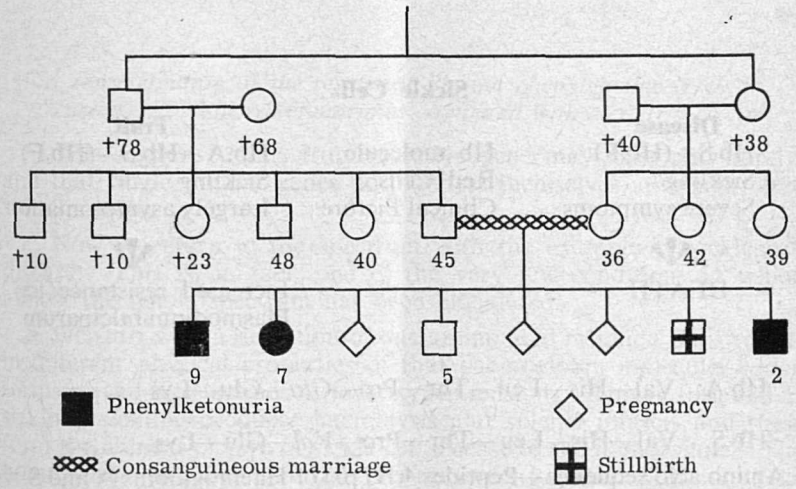
Section 4. As I have stressed, still very little is known in this field.

Section 5. This is the realm of the clinician, and it is from this point that I wish to view the other parts of the spectrum.

Section 6. Finally we consider the race and its evolution. Genetists and social workers are considering the effect of a diseased individual on the population, in the same way as a pathologist considers the effect of a pathogenic organism on the body.

What systems of defence, what buffering mechanisms does the population possess; and above all, what will be the effect of doctors saving those of an unfavourable constitution that naturally would have been eliminated from the population? Are we eventually going to get towns full of phenylketonurics? First, taking the specific example mentioned, phenylketonuria. This is a condition where there is a lack of phenylalanine hydroxylase, behaving as a recessive condition. It only manifests in the homozygous state. If one studies the pedigree of these recessive conditions (as are many of the metabolic inherited

A pedigree of a family with phenylketonuria



diseases) it becomes apparent that there is a great increase in the incidence of consanguineous marriages as compared to the normal.

Modern genetics counselling with proper detection of carriers can actually decrease the incidence of the disease by preventing consanguineous marriages. Admittedly, this decrease would not be permanent; but as the recent Eugenics Society symposium emphasised, population increase and economic problems would take a controlling effect long before the population became saturated with carriers of phenlyketonuria. To consider the whole of the spectrum in detail would be to consider the whole of medicine and biology. The object here is to consider the rest of the spectrum from the clinical viewpoint in an attempt to understand what accounts for the diseases we see and their characteristic pattern of inheritance.

I am in no way condemning the use of the terms dominant, recessive, intermediate and sex-linked; which incidentally appear to be the sum total of the genetics taught in standard medicine books. These concepts have been invaluable, and in the past have been adequate, when the clinician had only to recognise these inherited diseases, and advise on their form of transmission. However, with recent and future development of methods of control and treatment of inherited disease, these concepts will be inadequate. It is only with this belief that I can attach clinical importance to this paper. It must be realised that the terms, dominant and recessive, depend on the level of observation; and that they are all approximations rather than absolute. To consider sickle cell disease is an excellent example. Sickle cell disease occurs essentially in negroes and is characterized by the production of an abnormal haemoglobin—Hb.S—which in turn results in the "sickling" of red cells at low oxygen tensions. The disease has the features of a severe haemolytic anaemia plus the effects of the red cells sickling *in vivo*, producing infarction. It occurs in two forms, the disease proper and the largely asymptomatic sickle cell trait.

Sickle Cell

Disease		**Trait**
Hb.S + (Hb.F)	Hb molecule	Hb.A + Hb.S + (Hb.F)
Sickling	Red Cells	Sickling
Severe symptoms	Clinical Picture	Largely asymptomatic
⇓		⇓
DEATH		Increased resistance to Plasmodium falciparum

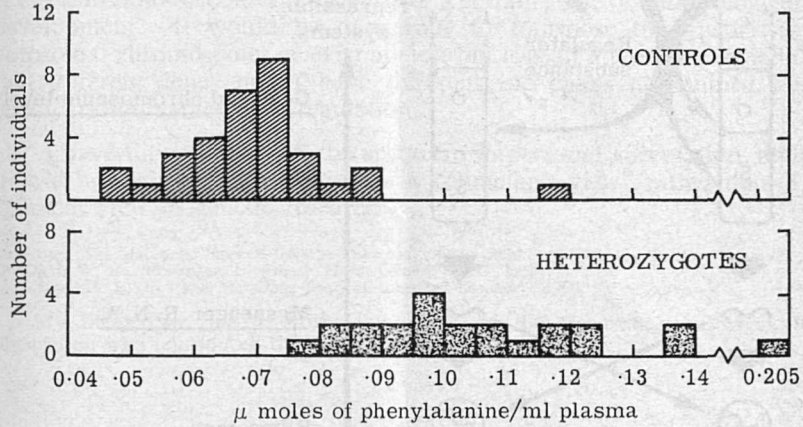
Hb.A: Val—His—Leu—Thr—Pro—*Glu*—Glu—Lys .....

Hb.S. Val—His—Leu—Thr—Pro—*Val*—Glu—Lys .....

Amino acid sequence—Peptides 4(BTpI) of Haemoglobins A and S.

It can be seen that taking the patient and his symptoms it appears to be recessive. Taking the Sickling phenomenon it appears to be dominant; and going into it further and examining the types of haemoglobin it appears as an intermediate type.

The metabolic pathways of man are so arranged that often they have the ability to counteract slight alterations in the concentration of circulating chemicals; and so maintain their normal function. This safety margin as it were, renders subjects with slight alterations in chemistry, normal in function. This situation exists frequently in the "carrier" or heterozygous state of some of the so-called recessive conditions—like phenylketonuria. They are called recessive because the "carriers" are apparently normal; but with the use of sensitive chemical tests, especially "loading" tests, deviations from the normal can generally be demonstrated.



A representation of the results of Plasma phenylalanine levels in "carriers" for Phenylketonuria as compared with a control group.

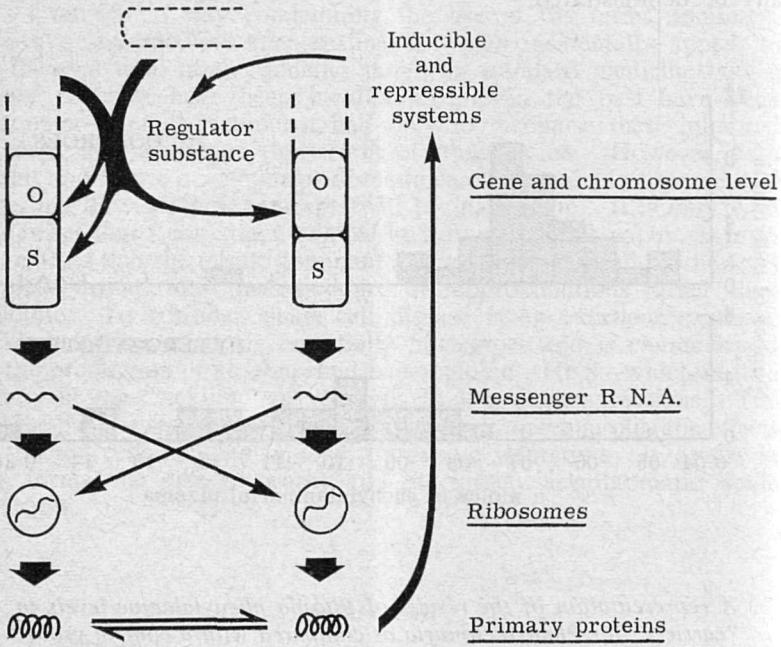
This suggests that a truly recessive gene may exist only rarely; and that single mutant genes do manifest themselves, although often sub-clinically.

Now to return to the spectrum with the example of sickle cell disease. This is, in fact, one of the very few conditions in which almost the whole spectrum has been elucidated.

We start with a deviation of one amino acid residue. This results in different physical properties of that haemoglobin molecule, which forms crystal-like tactoids at low oxygen tensions. This in turn causes sickling, sickling produces haemolysis and splenic infarcts and these form the clinical picture of sickle cell disease in the homozygote. The homozygote will die and thus be removed together with its sickle

genes from the population. However, the heterozygote maintains the incidence of the sickle cell genes in malarial infected countries, by bestowing the carrier with resistance to the deadly malarial parasite "Plasmodium falciparum". This demonstrates how the change in a single amino acid residue can radically alter the evolution of a race.

Finally, I want to venture further down the spectrum in an attempt to explain the mechanism of the dominance and recessiveness of a gene. This field is more full of questions than answers, although both are instructive. The dominance of one allele over the other, as defined clinically, can occur at a variety of levels.



Gene Action and Interaction (modified from Morod and Jacob, Ingram and Waddington).

Do structural genes dominate each other? This is unlikely in view of Morod and Jacobs' work; which suggests that any differential control of the expression of structural genes is mediated through diffusable regulator substances. The regulator substance of one allele could in some circumstances inhibit the action of the other. A protein produced by one allele could act through inducible or repressible systems to influence the regulation of the other allele. (In the book of Stanbury et al.), Sutton H. E. suggests that a mutant structural gene

may produce a protein that is "nonsense" as regards a particular enzyme function, but that may "make sense" as a regulator substance. Dominance may well be at ribosome level. It may be that the messenger R.N.A. from various genes compete for the ribo somes in the cytoplasm. Thus a mutant gene may be dominant by blocking sufficient ribosomes with "nonsense" R.N.A. and prevent sufficient normal protein being formed, This would result in the loss of a particular function possibly producing a "dominant" clinical condition. Work reported by Ingram (1963) on thalassaemia supports the concept.

Recombination at the primary protein level may occur as has been reported by Itano working on the recombination of the polypeptide chains in abnormal haemoglobins. Much work has been done on sex-linked conditions, since in such cases, in the male, a single allele can be studied. The only point I wish to mention here is the concept suggested by Lyon (1961), that, in the female, one or other of the X chromosomes becomes inactive after a certain stage of embryological development. It would be dangerous to transpose this theory to autosomal chromosomes or even alleles; but it is an interesting thought that different genes might have different life spans determined by disintegration rather than regulation.

I have finished way off the spectrum in personal speculation, and should honestly offer this paper as a "clinician's view" rather than a "clinical view of genetic research".

(1) From "The Metabolic Basis of Inherited Disease", Kobayachi et al. Shônika Rinskô, 5. 6. 1952.
(2) Knox, W. E., Messinger, E. Am. J. Hum. Genet. 10. 53. 1958.
(3) Sutton, H. E., in "The Metabolic Basis of Inherited Disease", 1960.

My thanks are due to Miss G. Sanders, of the Department of Medical Illustration who reproduced the diagrams of this article.

GEORGE GERHARD EXNER

George Exner was amongst that sturdy group of South Africans who came to Guy's after World War One, and who were the backbone of our Rugby side and a terror to our opponents. He was one of those giants who was eminent in most fields—no problem seemed too difficult for him. His chief love was the surgery of the mouth, and his readiness to lecture on any subject has been gratefully appreciated by a generation of dentists.

In his hobbies he was equally expert. In Iceland, Scotland, Norway and on his beloved River Test, grouse, salmon and trout were his summer and pheasants his winter pastimes. It was commonplace to see two birds cleanly killed and both still high over his head. He shot rogue elephants and rogue lions. He was an artist with his camera and made a large collection of big game photographs and films. His own trophy is still the record head for the Sudan giant Eland. A strong, tough man and a grand friend, magnetic dynamic and courageous. We will not see his like again and he will be missed by all who knew him.

MEDICAL PRACTICE and the MAGNA CARTA

R. K. Allday

In this 750th anniversary year of the signing of the Magna Carta, when the conditions of the practice of medicine in Britain are under searching scrutiny, it is perhaps fitting to examine the bases from which British Medicine and British Politics have grown.

Much of the troubled state of medical practice here today lies in the difficulties encountered in the integration of medical practice into the framework of the modern State as it exists in Britain. Whilst it is tempting to presume that the problems must, or will, be solved by manipulation of the lesser (medical practice) to enable it to be integrated into the greater (The State) it must not be forgotten that distortion of the lesser may be necessary to achieve this. If the structure or framework of the State is indeed that which is truly desired by the Nation then any alteration in the nature of medical practice enforced by its integration into the conditions of existence today must be accepted as desirable. If, however, the evolving structure of the State itself has deviated from the true path of natural development, as a result of artificial stimuli, then the enforced integration of medical practice into The State as it is will not be in the true interests either of The State or of Medical Practice.

Now the Magna Carta itself, sealed by King John on 15th June, 1215, under considerable duress of political pressure, has not lived in the minds and traditions of the English-speaking peoples for three-quarters of a millennium without good cause. Although not itself touching on the rights of the "common man", who in the Thirteenth Century was of no account at all, it established a basis from which the primary political rights of the common man have grown.

Although expressed variously by different historians, the basic ideological political rights established by this Charter were, and are, the rights of the individual to possess himself and the product of his own labour. These concepts developed into Habeas Corpus and "No taxation without representation": the denial of these principles has, in the history of the world, led to much bloodshed, not excluding the Second World War; the denial of the latter principle in particular led to the birth of the United States of America and much that followed.

It is perhaps because the establishment of these as political rights is merely giving recognition to what are basic human rights that they have endured as guiding principles for the English-speaking peoples for so long: in the present context it is the latter which is of especial significance.

"No taxation without representation" is not an empty phrase merely requiring a nominal seat in an assembly to justify taxation. It is an assertion that the individual shall not be obliged to labour (money is but a token for the exchange of labour) other than in his own interests. That taxation is acceptable at all is merely an acknowledgment of the benefits of association with other individuals to achieve what the individual cannot achieve for himself by himself alone. Indeed, an acknowledgment of the desirability of "government".

Now the process of evolution of government in Britain, at least from the statutory recognition of the principle in the Magna Carta, has been along the line of establishing an over-riding law to which all, including the supreme authority itself, were subject. In the beginning it concerned the king and the barons, it came to concern the monarch and all men and this in turn has led to The Government, The Monarch and The People all being subject to the authority of Law.

Initially the barons, later it was the people who ensured that the ruler did not establish laws favouring himself and prejudicial to the individual. That just laws evolved was due as much to the faith of such rulers as Edward I in the principle of law as to the watchful eyes and turbulent spirits of the subjects It is no less important today that the watchful eyes of parliament and people ensure that laws are not formulated (or if already formulated allowed to remain) which unjustly favour "Government" to the detriment of the rights of the individual.

It should today seriously be questioned as to whether Government should have the right to tax individuals, not for their own benefit, but for the personal benefit of other individuals. This is not to question the right of all men to contribute via channels of government to the benefit of other individuals, but to question the right of Government to demand that they shall so do.

The significance of establishing—or re-establishing—this principle in national politics today might be of great, and perhaps over-riding, importance for the satisfactory solution of the problems involved in the proper integration of medical practice into the society of today.

Medical practice is of two types in the modern community.

There is that form of medical practice which generically falls under the classification of "Public Health" and which is the practice of medicine designed primarily for the benefit of the community and only incidentally, if at all, for the benefit of the individual. Thus meat inspection benefits all and only incidentally the ones who would otherwise suffer. The action taken to deal with a case of smallpox from a Public Health point of view is directed to control the spread of the disease in order to prevent others suffering and only incidentally to aid the afflicted individual. (Public Health matters are not necessarily co-incident with what is today provided by the Public Health Services.)

The second form of medical practice is that of the "Personal Health Services". This can range from advice from a doctor to a patient, to extraordinarily complicated procedures involving large numbers of highly trained individuals doing something to or for a patient. The essential difference in this second form of medical practice is that its primary purpose is to provide benefit for the individual

and only incidentally to benefit the community. (The benefit to the community may come in the form of a healthy man able to work, in the increase of medical experience, in the resultant dissemination of medical knowledge or other ways.)

Now these two forms of medical practice are, economically, politically and to some extent medically as well, essentially different in that one is for the benefit of the community whereas the other is for the benefit of the individual. There is thus a different responsibility for "Government" and The State to consider in the different fields.

For the first type of medical practice it should be the responsibility of Government to provide the service. To do this it must acquire the labour to carry out the task and to this end it must acquire the money by taxation. It is a matter for Government to decide on the type of service required (necessarily on the advice of experts) and the level of taxation needed.

For the second type of medical practice different considerations arise and failure to understand this may be one of the major reasons for the present difficulties of medical practice in a state controlled health service.

It must be realised that medical practice is only a form of help to enable the individual to regain or maintain health. The quantity and quality of help required varies in every case and no stereotyped form of help can be provided, nor would it satisfy the needs of the patients if it could be so provided.

In many cases of need the quantity of help required is small but in some it is extremely large. In wisdom, since the occasion of large need cannot be foretold, and in humanity since in many cases, even if the need could be predicted, the individual would not provide for it, some form of insurance is desirable.

Now it is surely a permissive right of government to organize and administer an insurance scheme for the potential benefit of all the people and also to encourage the charity of the healthy members of the nation in providing for their less healthy neighbours. It does not, however, seem necessarily true that it is the duty of government to enforce participation in an insurance scheme on everyone if the individuals do not wish to avail themselves of the benefits offered. Indeed to do so is very suggestive of the reverse of "No taxation without representation". When this is not even necessary for the scheme to work for those who do wish to avail themselves of it the permissive powers of government might seem to have been exceeded very considerably.

Nor, however, is this the full extent of seeming infringement of basic rights. By extracting from every individual that proportion of his income which he has for purchase of medical help the State has left the individual without any income which should properly be used for purchasing medical help if *anything* other than State Medicine is desired.

Not only has The State prevented every individual from having any proper income with which to purchase non-State Medicine it has

also grossly interfered with the ability of the individual to indicate what type of medical practice he does desire. Instead of demand stimulating supply it is now a question of the supply of medical services (as authorized by the State only) endeavouring to limit the demand.

No longer is it possible for medical practice to offer the best of that which it is capable to test if the demand exists, for the demand has necessarily been inhibited.

No longer is it possible for the individual patient to have a need differing from the accepted pattern with any hope of its fulfilment: the supply is restricted to what the State has decided that the individual should want.

The history of medicine extends over some five thousands years: dim in its origins more and more is known as the centuries unfold.

The medicine of Ancient Egypt flourished, producing more than as yet we know, but it became extinguished with the fall of the culture and a too rigid adherence to the science of the day.

Medicine in India in the first millennium B.C. flourished; Chandragupta made the care of the sick the responsibility of the State; hospitals arose in great numbers but the rigidity of the religious culture suppressed the continued evolution of medical practice and it sank into obsurity. In China, in the civilizations west of the Andes, and in Mexico, systems of medicine arose and perished. Greek medicine evolved, it spread westwards to Rome and eastwards to Jundisapur, whence it returned to Europe via the North African littoral with the Moors and into Spain. Both these branches of Greek medicine, although the Arabian was enriched by contact with thought from India and perhaps from China, almost perished because of the rigid structures imposed on progress; the Arabian because of the unbending laws of Islam and the Roman partly because of the "revealed science" of Galen and partly by the intransigence of the hierarchical Christian church.

However, with the liberalizing of men's minds, promoting and in turn promoted by the Renaissance, fresh progress was made. The medicine of Hippocrates of Cos, rescued by the determined and courageous pursuit of truth by such men as Vesalius, spread northwards from Italy and into the continent of Europe and over the narrow seas to Edinburgh and London. Britain, from the early seventeenth century, has contributed much, perhaps more than any other nation of the world, to the progress of medicine both in its science and in its art.

Wherever man has been free to develop his potentials, whenever rigid adherence to preconceived ideas has been overcome, so also has medicine progressed.

In the perspective of history, artificial restrictions on other cultures and other nations are easier to see than any that might be operating here and now. Present artificial strictures, however, are no less inhibiting to the natural progress and development of the medicine of today than were others in the cultures of the past: it is merely less easy to determine what they are.

For the greater benefit of medicine and the Nation the freedoms established in the past, on which the Nation as a nation has grown and within which British medicine has developed, should not be allowed to be obscured by temporary expediency either in medicine or in politics.

To quote the words of one of the greatest protagonists for freedom—one of the greatest Britons of all time:—

> "And when in subsequent ages the State, swollen with its own authority, has attempted to ride roughshod over the rights or liberties of the subject it is to this doctrine [of the Magna Carta] that appeal has again and again been made, and never, as yet, without success."

(Sir Winston Churchill: *A History of the English-speaking Peoples.* Book II, Chapter VII)

CORRESPONDENCE

Sister Falwasser

SIR,—May I, through the courtesy of your columns, thank all those who so generously contributed towards a magnificent cheque, which I have recently received together with a book of signatures, as a " retirement present " from my Guy's friends.

To thank each one concerned individually would indeed be a formidable task, but as I try to decipher the signatures, trace maiden names, and ponder somewhat nostalgically over the years gone by, I glow with gratitude.

I am truly grateful for this gift which enables me to add comforts, and indeed luxuries, to my tiny house.

Should any of you pass this way at any time, do visit me. It could always be combined with a little historical or archaeological research in this interesting city, and what pleasure it would give me!

Yours, etc.,

ANGELA FALWASSER.

65, Canon Street,
Winchester,
Hants.

Homosexuality

SIR, Passim (26th June, 1965) put forward the age old and specious argument that deviations from normal or "correct" behaviour "should be repressed by the individual conscience which is fully aware of the consequences . . . " It might be asked how many consciences are *fully aware* of the "consequences of sexual deviation". Furthermore, most consciences are aware of the danger to self and society of murder, rape, stealing, lying, cheating, etc., but these things still happen. If your argument were correct, we could scrap our police force and law courts and save ourselves a great deal of money.

The treatment for people who "deviate" is always twofold; A sympathy and treatment for their trouble and an attempt to prevent them from harming themselves or others, if conscience and treatment both fail. People know that it is dangerous and foolish to dash across the road without looking. The installation of pedestrian barriers and even the imposition of fines for carelessness are surely reasonable and in the best interests of the offender. Human nature is such that it tends to "slip up" if all restraints other than conscience are removed.

Yours, etc.,

T. H. S. BURNS

"Newlands",
Edgehill Road,
Ealing, W.13.

MEDICAL STUDENT COMMITTEE EDUCATION

At a meeting of the Student Medical Education Committee on Thursday, 24th June, the following points were discussed with the future Dean and Sub-Dean. Discussion was based on the Committee's first report.

1. **Firms.** (a) In general the students thought that the firms were too large for the maximum benefit to be attained from them. Plans are now under way to alleviate this situation.

(b) Some students complained that certain firms were too "specialised", for instance, where the consultant has a particular interest, e.g., the chest, and that they were gaining an incorrect impression of the incidence of diseases.

It was considered unnecessary that the student should see every disease during his medical training. Those conditions not met with on ward rounds etc., could be supplemented by lecture material and personal investigation, whether by reading or enquiring from a member of the staff. However, Registrars were being informed of the students' comments.

2. **Rounds.** The opportunity of sitting down during rounds was requested by many students, and that some physiology and more discussion about pathology and methods of treatment be introduced in rounds.

This was considered a matter for those conducting rounds. The inclusion of physiologists and pathologists was considered extremely valuable but unfortunately a shortage of both made their presence at rounds impractical for the time being.

3. **G.P. Attachment.** Many students thought this scheme worthwhile but only about 50 per cent availed themselves of this opportunity. The Committee considered it essential that every student should have some insight into general practice and hoped that in future the scheme might became compulsory.

The number of G.Ps. willing to take students is by no means limited but it has been found very difficult in the past to arrange for a time which was convenient for both the student and the G.P. It was agreed that the idea of the scheme was to give the student some insight into the work of a G.P. and not to teach him general practice. However, Dr. Smith, of the G.P. Unit, would be approached for further help in this scheme.

4. **Preliminary Clinical Period.** A course on the management of accidents and more time spent on teaching and demonstrating how to perform routine investigations was requested by many students.

A First Aid course has already been started and students will be able to sit an exam. at the end of the course. Concerning the teaching of routine investigations, Dr. Lessof is being approached on this matter.

5. **Laboratory Facilities.** (a) Many students feel that the present facilities in the laboratory are inadequate, in particular the lack of good microscopes.

Dr. Houston replied that a Technician has been appointed to look after the students' laboratory and also to be on hand to give advice to students when needed. The facilities are going to be improved and will include electric colorimeters. It is hoped that with better facilities the students will take more care to keep the laboratory clean and tidy.

(b) Many students commented on the lack of haemocytometers available for loan from the medical school office.

Both haemocytometers and ophthalmoscopes are to be put on the list of items considered essential for the course and will therefore be covered by the students grant.

There is to be a new scheme whereby haemocytometers can be bought from the Medical School and sold back at the end of the clinical course, if so desired.

6. **Psycho-Sexual Problems.** The Committee thought it essential that the student should have some insight into such problems and it was suggested that attendance at Marriage Guidance Councils and Family Planning Clinics would help in this respect.

Dr. Houston considered the former impractical as people went to Marriage Guidance Councils on the understanding that their interviews would be confidential, and that the presence of medical students in the same room would not be allowed. However, Dr. D. Stafford-Clark has agreed to give a course of lectures on this subject. The attendance of students at Family Planning Clinics is being looked into and a member of the Staff is being asked to give a series of lectures concerning this subject.

7. **Tutorial System.** There seems to be an almost unanimous support amongst the students for this, and the whole question is being looked into by the Student Education Committee and the Staff.

8. **Speed Reading.** It was reported that speed reading courses are available in London. It is being investigated as to whether a course of lectures could be given at Guy's.

Tropical Medicine

A course, organised by the British Medical Students' Association, is being held at the London School of Hygiene and Tropical Medicine between 19th and 30th July, on medicine in the Tropics. Medical students from many countries will be participating, and anyone from a London Medical School may attend all or some of the lectures for 10/-.

Full details will be posted on the notice boards.

GUY'S HOSPITAL THEATRE CLUB

HUIS CLOS
by
JEAN PAUL-SARTRE

"Huis Clos", the best known of Monsieur Sartre's plays, was first produced in occupied Paris on D-Day plus ten. Sartre works out a plan for the hereafter in the situation of three newly dead people confined eternally to a single room. The room is simply a locked room. Not a heated torture chamber, not Valhalla either. But no one comes or leaves apart from the fitful visits of a valet-gaoler.

The three characters circle around each other and the onion skins begin to peel off. They discover their secrets. Occasionally they are tortured by a glimpse of earth and the knowledge of how they will be remembered. Eventually they reveal the reasons for their damnation, and at last realise that their own hell is to live together; three unchangeable people, chosen for their common incompatibility, and denied any of the comforts and self-deceptions which had supported them in life. The play ends as this realisation becomes complete, and eternity is just beginning—" . . . Well, let's get on with it. . . ."

This is a fascinating and difficult play, with a tiny cast, very little "action", and very intense dialogue. Christopher Davis, the producer, took a gamble with it at long odds, and he made a rich killing. The earliest hint we had that things would go well was in the careful attention to detail. The programme was a classic design, the lighting was striking and confident, the make-up was faultlessly in tune with the lighting, and we sat down in front of a set which was quite special. For once, the theatre was suited to the play. Neil Watson used the flower vase quality of the auditorium to its best advantage—on a raised stage (which takes several stage hands a whole night's work to build), there hung a strong, menacing, beautiful cage. Very simple and very, very good.

Into this room comes Joseph Garcin, deceased, pacifist, coward and wife-torturer. With him the ghoulish presence of John Froude's muted sub-human valet. This small part was neatly done, and complimented Garcin's opening questions with sinister ennui. We did wonder if the powder on his trousers had any unspeakable symbolistic significance? John Stephens, as Garcin, speaks first. His opening lines were beautifully controlled—the balance of edginess, uncertain authority and terror allowed the audience to relax, forget its concern that the evening should go well, and begin to listen in the certainty that it would. Garcin carries the play, and in this John Stephens succeeded well, and he was never better than in the first moves.

He is joined by Inez, the cruel little lesbian clerk, and last by Estelle—beautiful, rich, narcissistic and the murderer of her baby. Christine White was remarkably good as Inez. We soon knew in advance when her destructive, accurate gibes would strike, and we waited for the revenge when her desired Estelle had spat in her face.

Estelle herself, was played by Lorely Ide—what a name for the stage as a start. She was best in the earlier moments, and only became rather lost when fondling Garcin. This was disappointing in such a reputedly experienced adulteress. The actors, then, showed talent, but the whole evening depended on Christopher Davis's ability to make them gel.

This production had style all right. Through the whole play the emphasis was on economy of movement, on simplicity and on playing-down the crisis. This style would have pleased Cocteau—"A very simple way of saying very complicated things". It came across as a finished, rounded concept of Sartre's idea and developments and I think it worked completely.

To claim perfection for this production and its players would be absurd. There were odd moments of unintentional farce, of inhibition, even of anti-climax. Of course there were. But the whole evening was a definite success and I, for one, would have gone on the third night had there been one.

Christopher Mallinson.

REVIEWS

HEREDITY:

An Introduction to Genetics. A. M. Winchester. Harrap & Co., 18s.

It is becoming increasingly evident that Genetics should be regarded as an essential part of the medical curriculum—Professor Hurst has called it " the New Basic Science in Medical Education." In this, as in most subjects, the entirely adequate textbook has yet to be written. This book has much to commend it—yet perhaps, not quite as much as the preface would have us believe. It should, we are told, be of value to " the medical student . . . as a valuable reference" to those "interested in the behavioral sciences . . . as a useful guide", to "practising physicians, psychologists and counsellers" dealing with marriage problems, " members of the legal profession " (for " even criminal investigations may often be solved through genetic means"); and, in fact, to any person furthering his self-education.

This seems a clearly written and surprisingly thorough outline of genetics, from Black Hampshire boars to parahydroxyphenylpyruvic acid. The book has a large number of clear and vivid diagrams, in contrast to the spidery illustrations often found in such textbooks. While the subject of genetic mutation is well covered, it seems unnecessary to go into High Energy Radiation in quite such detail—atomic structure, scintillation counters, reps, rads and rems, seem outside the realm of pure genetics. Nevertheless, this seems a readable and thorough introduction to the study of genetics, and at a reasonable price.

M. Simpson.

PARKINSONISM

by Gilbert Onuaguluchi. Butterworth, 1964. 168 pp. *Price* 55*s*.

This monograph is based mainly on the experience of the author in two post-encephalitic wards containing sixty-seven patients. It deals first with aetiology, and with the physiological mechanisms involved in maintenance of muscle tone and in the production of tremor.

The clinical features of Parkinsonism and its sequelae are described. The chapter on Crises is especially interesting. The management of Parkinsonism is discussed briefly. There is a detailed pharmacological analysis of possible sites and modes of action of drugs used. The final chapter on the assessment of drug therapy in Parkinsonism is also very interesting. This book does not pretend to be comprehensive. The lack of balance between sections is a reflection of the author's interests as pharmacologist and as clinician responsible for the care of patients in the ward. It is easy to read, and will be of value to undergraduate as well as postgraduate neurophiles.

A. N. BOWDEN.

DRUGS IN ANAESTHETIC PRACTICE,

by F. G. Wood-Smith and H. C. Stewart. 2nd Ed. Butterworth's. Pp. 523. *Price* 75*s*.

An anaesthetist and a pharmacologist have collaborated in producing this book, which contains much valuable information Some of it does not appear to be directly relevant to anaesthetists, e.g. the sections on uterine stimulation and on enzymes. There is a good section on electrolytes and infusion fluids.

In this revised edition coming within a few years of the first edition, some new drugs have been included and alterations have been made in some sections. A chapter on antibacterial drugs written by a well-known expert has been added, and the section on oxygen, carbon dioxide and helium has been removed. As in the first edition each drug is dealt with under the headings: physical characteristics, pharmacology, indications, dosage and administration and precautions. The chemical formulae, chemical names, pharmacopoeial names, trade names and synonyms are given. Comparatively little is said about mechanisms of action. There is no discussion on the relative merits of different drugs with similar properties. The book is easy to consult, but not really suitable for undergraduate reading. The authors, in fact, emphasise that their aim is to produce a book of reference suitable for post-graduate study.

The only serious criticism is the scarcity of references in some sections, e.g. there are only six references in the section on antibacterial drugs, two of which are later than 1956.

J. M. ROBSON.

BEDSIDE NURSING—AN INTRODUCTION.

by J. Darwin, J. Markham, and Brysson Whyte. Heinemann, London. 1965. *Price* 15*s*.

This book, although written primarily as an introduction to bedside nursing for the enrolled nurse, is of value to nurses of all grades. The well written text is clearly set out, and the illustrations are simple, relevant and informative. Starting with admission to hospital, the book covers all aspects of patient care, both from a physical and mental aspect. Throughout there is a bias towards the patient's requirement with specific chapters for the elderly, the young, the paralysed, the unconscious, etc. Patients appreciate the nurse who makes them comfortable and happy rather than the one who is pre-occupied with details of electrolyte balance. Of course, nurses need to understand such details but in doing so many fail to appreciate the patient's fears and discomforts. This book concentrates on the patient, giving at the same time a concise background to illness, details of routine treatments, principles of sterilization, prevention of infection and other topics necessary to enable a nurse to work intelligently. Professional terms and definitions have been skilfully introduced in an uncomplicated manner to give a basis on which further knowledge can be built. No text book of nursing will satisfy everybody since individuals have their own ideas and methods, but this book provides a sound basis of principles as an introduction to bedside nursing, which, after all, is what it sets out to do.

H. HYDE-WHITE

SPORT

UNITED HOSPITALS ATHLETIC CHAMPIONSHIPS

In this meeting, Guy's retained the title with an impressive victory over the other hospitals. At no stage during the afternoon were Guy's placed anywhere except first. At the final count, Guy's had gained more than twice as many points as St. Thomas's, who were placed second. This meeting completed a very successful season in which Guy's have won all four of the University and United Hospitals' Championships.

Some heats and finals were held on the preceding Wednesday, and in the finals Guy's established an early lead by gaining first and second in the hammer, thanks to some very able throwing by Peace and Bailey. Bates and Domaingue gained useful points in the triple jump, but what was more significant was the fact that Guy's had two competitors in every final on the Saturday.

In the first final on the Saturday, I. Morgan ran superbly to win the quarter-mile hurdles in a time comparable with that which gained him A.A.A. status earlier this season. In the high jump, R. Morris completely outclassed all opposition and went on to win comfortably by a margin of nine inches. J. Domaingue demonstrated his versatility in the jumping events by gaining fifth place in this event.

The weight and throwing events were personal triumphs for Peace and Edwards, the latter producing a very good throw to win the javelin event. Bailey and Quinnell provided able support, and both were well placed in these events.

The outstanding performance of the afternoon was in the half-mile. With 220 yards to go Wheeler was lying third, with Choat well to the back. At this point Choat put in a magnificent finishing run which brought the Guy's supporters to their feet. Their times were some four seconds better than their previous best.

In the sprints, Barford and Nwator were placed third and fourth respectively, and in the quarter-mile, Morgan, running the second of his three quarters, finished a good second behind the university champion.

In the long distance events the Hospital was well represented by Wilson, Witting, and Wheeler. All three were well placed in events in which Guy's are traditionally weak.

A very efficient tug-of-war team, astutely coached by Mr. Tomkinson, pulled its way to an impressive victory over St. Thomas's in the final.

The relays were somewhat disappointing with Guy's placed second and third in the 4 x 110 and medley respectively.

In the eighteen events Guy's athletes gained six first places, and it is obvious from these facts that the enormous number of points gained were largely due to the ability of the second string athletes to gain third or fourth places. This victory, by the largest margin in the championships' eighty-seven years history, was due to the great effort of all concerned, and marks the continuance of the Hospitals' strength in athletics, following some years of individual strength but overall weakness.

Results

1st—Guy's, 155 pts. 2nd—St. Thomas's. 3rd—St. Mary's.

100 yds.—3rd, D. Barford; 4th, F. Nwator.
220 yds.—3rd, D. Barford; 4th, F. Nwator.
440 yds.—2nd, I. Morgan, 50.2 secs.; 4th, Winskill.
880 yds.—2nd, D. Choat, 1 min. 56.9 secs.; 3rd, J. Wheeler, 1 min. 57 secs.
Mile—5th, J. Wheeler.
3 miles—5th, P. Witting; 6th, J. Wheeler.
Steeplechase—3rd, P. Witting; 6th, R. Wilson.
440 Hurdles—1st, I. Morgan, 55.2 secs.; 3rd, A. Winskill.
120 Hurdles—2nd, A. Winskill; 3rd, J. Domaingue.
Pole Vault—2nd, G. Edwards; 6th, W. Annan.
Shot—1st P. Peace; 3rd, R. Quinnell.
Discus—1st, P. Peace; 3rd, R. Bailey.

Hammer—1st, P. Peace; 2nd, R. Bailey.
Javelin—1st, G. Edwards, 181ft. 3ins.; 3rd, B. Hartley.
High Jump—1st, R. Morris, 6ft. 3ins.; 5th, J. Domaingue.
Long Jump—2nd, R. Morris; 3rd, J. Domaingue.
Triple Jump—3rd, M. Bates; 4th J. Domaingue.
Tug-of-War—1st, Guy's; 2nd, St. Thomas's.
4 x 110 Relay—1st, Westminster; 2nd, Guy's; 3rd, St. Thomas's.
Medley Relay—1st, Westminster; 2nd, St. Thomas's; 3rd, Guy's.

RUGBY FOOTBALL

At the Annual General Meeting of the Rugby Football Club, the following elections were made:—Captain, J. E. Davies; Secretary, B. Rowlands; Assistant Secretary, R. Beecham; Secretary of the Junior Teams, J. G. Payne; Secretary of the School's Team, H. C. Sharp.

HOCKEY

The Guy's Hospital Hockey Club held its A.G.M. on 18th May at 6.30 p.m. in the Students' Common Room, and elected the officials for the 1965-66 season.

The Club showed its appreciation of the continued support and interest of Professor Butterfield, by the manner in which he was unanimously re-elected as President of the Club. In the same way, Professor Emslie, Dr. Scott and Mr. Bridge were also re-elected. The Club is indebted to Mr. St. Pierre, who served as Vice-President during the past year, but was unable to stand for re-election as his work now prevents this. The Club unanimously welcomed two worthy new Vice-Presidents, Mr. Gazet and Dr. Hunter-Craig. Dr. Hunter-Craig has done a great deal for the Club in the capacity of umpire for the 2nd XI, and his election to the hierarchy of the Club is well deserved. The following officials were also elected:—Captain, C. A. Brooks; Team Secretary, S. Rear; Match Secretary, R. Carruthers.

Reports and Results

TENNIS

This season the 1st VI has lost only two matches—against Imperial College and Midland Bank. The latter match was played a fortnight ago on their courts at Beckenham; it was a grand sunny afternoon, with evenly balanced teams, very good grass courts, and high-class friendly matches. At tea-time the score was 3—2 to them with the other match left at one-set all, only to be finished if the result hung in the balance. After tea, however, we were just unable to bring about this state of affairs because with the 1st pair winning and the 3rd pair losing, the 2nd's just went down 2—6, 6—4, 9—7—having lost two match points! The team consisted of S. Hopkins, R. Machett, H. Sharp, P. Swiss, J. Siegle, and J. Davies.

In preparation for our semi-final Cup match against Bart's on Wednesday, 7th July, we play Lloyds Bank on the 4th and R.N. Greenwich on the 6th in an evening match. The team for these matches is J. Hopkins and B. Haylow, R. Machett and J. Newman, H. Sharp and P. Swiss—the captain.

CRICKET

GUY'S v. BALCOMBE.

At Balcombe. Saturday, June 5th.
Result: Won by 9 wickets.

Balcombe won the toss and elected to bat. They were soon in trouble against our opening attack, and wickets began to tumble. Even with the assistance of one of Guy's less regular bowlers, they could only muster a total of 87.

Butchey and Silk opened the batting confidently and thus runs came with no apparent trouble. Silk was eventually caught and bowled, leaving Butchey and Cutler to score the few runs needed.

Guy's had proved much too good for their rather weak opposition, and won the lower beer match that followed equally convincingly.

Scores: Balcombe 84 (Powell-Jackson 4 for 25), Guy's 87 for 1 (Silk 46).

M. I. Appleby.

GUY'S v. CROFTON PARK.

At H.O.P. Monday, 7th June
Result: Drawn.

At lunch, Crofton Park had lost 5 wickets for 77, but afterwards they recovered well and were able to declare at 189 for 7.

Guy's had scored 102 for 4, with Butchey going well when the rain came. A pity, because the game was nicely balanced at this stage; 88 runs were needed in the last 65 minutes with 6 wickets in hand.

Scores: Crofton Park 189 for 7 (Annison 48*, Davoodbhoy 3 for 48).

Guy's 102 for 4 (Butchey 48*).

GUY'S v. U.C.S. OLD BOYS

At H.O.P. Saturday, 26th June
Result: lost by 39 runs

A fine spell by Davoodbhoy who took 7 for 52 caused U.C.S. Old Boys to be dismissed for 109. This seemed an inadequate total, and the Guy's spirits were high at tea. However, good fast bowling by Welch and some poor batting produced only 70 runs. Silk and Griffiths were the only batsmen to reach double figures.

Scores:

U.C.S. Old Boys, 109. (Jenkins, 54.) (Davoodbhoy, 7 for 52.)

Guy's, 70. (Griffiths, 24; Silk, 22.) (Welch, 7 for 39.)

GUY'S v. QUEEN'S UNIVERSITY, BELFAST

At H.O.P. Wednesday, 30th June
Result: lost by 2 wickets

Guy's won the toss, and were given a steady

start by Butchey and Appleby. Cutler, coming in when Appleby was bowled with the score at 31, provided the backbone of the innings. After surviving some early chances, he batted attractively to make 76 not out. Powell-Jackson and Silk also played useful innings.

Queen's were set 164 to make in 130 minutes. Runs came at a steady rate. Butchey and Steer bowled well, and with 20 minutes left, both sides had a chance of winning: they needed 40 runs with five wickets in hand. However, 26 runs (three sixes and two fours) were scored off one over. This completely changed the situation, and they won in the penultimate over.

This was the first match of the Queen's tour. If the rest of their games are as good as this one, they will have a most enjoyable week's cricket.

Scores:

Guy's, 163 for 4 dec. (Cutler, 77 n.o.; Silk, 25.)

Queen's Univ., 166 for 8. (Cunningham, 53.) (Steer, 3 for 55; Butchey, 3 for 76.)

M. I. APPLEBY

GUY'S v. TEDDINGTON

At H.O.P. Sunday, 4th July

Result: lost by 3 wickets

Guy's won the toss and elected to bat. A slow opening partnership of only 39 in the first hour seemed to cause some of the later batsmen to play imprudent shots in an attempt to get the pace moving. However, the fall of further wickets in this way only worsened the situation, and when the seventh wicket fell with the score at 82 it looked as though Guy's were not going to make the ton. Fortunately at this stage, Knott played an invaluable and free-scoring innings, making the top score of 31, and then Beacham and Torrance, who was dragged from the tennis courts to replace a non-arrival, batted defiantly so that Guy's were able to set Teddington a target of 126 in 105 minutes.

The Teddington opening batsmen did not look in any trouble, and it was not until they had scored 50 that Taylor was run out. Now the tables turned and Davoodbhoy had the batsmen in trouble, taking a fine "hat-trick", something not done at Guy's for at least five years. It was all the more creditable because it consisted of batsmen three, four, and six, and not the tail as do most hat-tricks. When he took yet another wicket two overs later, and the score stood at 82 for 6, it looked as if Guy's could win, but the usual spate of dropped catches allowed Denny to make 41, having been given three lives, and Teddington went on to make the runs with three wickets and five minutes in hand.

Scores:

Guy's, 126 for 9 dec. (Knott, 31.)

Teddington, 127 for 7. (Denny, 41; Taylor, 34.) (Davoodbhoy, 4 for 35.)

J. K. CRAFTS

GOLF

Guy's had their most successful day at the London University championships for many years.

The team prize for the Beveridge Cup, for the best three thirty-six hole medal scores was won by—

D. Adams, 76, 76.
M. J. Brummitt, 75, 78.
B. Bevan-Jones, 80, 81.

The Individual Championship for the Eckhoff Cup, kindly presented in person by Mr. Eckhoff, was also won by D. Adams, with M. J. Brummitt runner up with the scores mentioned above.

The hospitality of the Denham Club was as good as always; the weather was perfect; and all 50 competitors, especially the Guy's team, enjoyed a great day's golf.

M. BRUMMITT

HOSPITAL INFORMATION

APPOINTMENTS VACANT

THE ROYAL MARSDEN HOSPITAL,
SURREY BRANCH, DOWNS ROAD,
SUTTON, SURREY

Applications are invited for the post of **Resident Senior House Officer.** This is a Post-Graduate Teaching Hospital, a radiotherapy centre with high-energy apparatus and 99 beds. Application forms can be obtained from the Administrator, to whom they should be returned as soon as possible.

APPOINTMENTS VACANT

GUY'S HOSPITAL
HOUSE APPOINTMENTS
September 1st, 1965

Applications are invited for the following House Appointments at Guy's Hospital, due to begin on September 1st, 1965, applications giving choice of post and choice of hospital, in order of preference, to be lodged with the Superintendent, not later than **July 30th, 1965.**

Assistant House Surgeons
Pre-registration 4

The appointment will be for six months, the first three to be spent as A.H.S. During the second three months of the appointment candidates will move either to the post of Casualty Officer (Surgical) or will remain as A.H.S.

These vacancies will normally be open only to pre-registration candidates applying for their first appointment and not to candidates seeking their second six months appointment.

Assistant House Physicians
Pre-registration 5

The appointment will be for six months, the first three to be spent as A.H.P. During the second three months of the appointment candidates will move either to the post of Casualty Officer (Medical) or will remain as A.H.P.

These vacancies will normally be open only to pre-registration candidates applying for their first appointment and not to candidates seeking their second six months appointment.

Casualty Officers
Pre-registration 6

House Surgeons (2)
Pre-registration 1
Pre- or Post-registration 1

House Physicians (2)
Pre-registration 1
Pre- or post-registration 1

Resident Obstetrician
Post-registration 1

Gynaecological House Surgeon
Pre- or Post-registration 1

Throat and Ear House Surgeon
Pre- or Post-registration 1

Neurological House Physician
Post-registration 1

House Surgeon to the Thoracic Unit
S.H.O. 1

Children's House Physician
Pre-registration 1
(2nd six months, or post-registration)

House Physician in Clinical Pathology
S.H.O. 1

House Physician to Dr. Bishop, Dr. Wayte, and Mr. McArthur
Pre-registration 1

House Physicians in the Department of Psychological Medicine
S.H.O. 2
(To commence 1.10.65)

House Physician in Child Psychiatry
Post-registration 1
(Part-time Guy's, part-time Evelina)

R.M.O. in Nuffield House
S.H.O. 1

Resident Anaesthetists (2)
S.H.O 1
Post-registration 1

The Medical Committee will also consider applications for posts at outer hospitals as follows:—

HITHER GREEN HOSPITAL
House Physician in General Medicine and Infectious Diseases
Pre-registration 1
(from 1.10.65)

JOYCE GREEN HOSPITAL
House Surgeon
Pre-registration 1
(from 23.8.65)
House Surgeon
Pre-registration 1
(from 25.9.65)

LEWISHAM HOSPITAL
House Physician to Dr. Llewellyn Smith
Pre-registration 1
House Surgeon to Mr. Cavendish
Pre-registration 1
(from 5.9.65)

NEW CROSS HOSPITAL
House Physician in Medicine and Geriatrics (S.H.O.) 1
House Physician in Medicine and Geriatrics
Pre-registration 1

ORPINGTON HOSPITAL
House Physician
Pre-registration 1
House Surgeon
Pre-registration 1
(To commence 1.10.65)

QUEEN MARY'S HOSPITAL, SIDCUP
House Surgeon
Pre-registration 1
House Physican
Pre-registration 1

NOTICE FOR PRE-REGISTRATION CANDIDATES

Pre-registration candidates are reminded that the number of posts at Guy's is small compared with the number of students who are likely to qualify. Students applying at Guy's, therefore, are advised to consider applying for pre-registration posts elsewhere at the same time, in order to avoid delay in obtaining a post. A number of recognised posts is available in the South-East Region. Details of posts in this region and elsewhere in the country are available in the Medical School Office.

Pre-registration candidates who have completed six months in Medical or Surgical posts are reminded that they must now apply for Surgical and Medical posts respectively. A candidate who has completed his first six months in a specialty (Surgical or Medical) may not do another six months in a specialty, but must seek a post in general medicine or general surgery as the case may be, according to G.M.C. regulations.

J. B. BLAIKLEY,
Superintendent

PASS LISTS

ROYAL COLLEGE OF SURGEONS OF ENGLAND

L.D.S. Final Examination. June, 1965

Part 1. Surgery

E. W. Blackwell
G. K. Dubuck
D. P. Fleming-Jones
R. N. Francis
Brenda Gilliam
Helen K. Hackel
B. K. M. Harborth
T. L. Harrison
A. J. Hawkes
P. G. Inward
P. V. Lawrence
A. D. C. Munro
S. L. R. Oakenfall
H. W. D. O'Connor
Elizabeth G. Reid
R. J. Ringrose
J. H. Siegle
C. J. Skinner

Part 2. Dental Surgery

A. J. Allan
Valerie J. Beaton
J. C. Bennett
J. D. Brammer
R. Brown
F. J. Chate
P. D. Davies
Margaret J. Evans
A. R. Fisher
B. D. Fitzgerald
Rosalind Harvey
K. J. C. Hughes
J. M. G. Hunt
R. S. Hunt
Christine M. Jones
P. L. Jordan
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A. J. Lakin
K. M. Lay
S. H. J. Lennane
E. D. Lettinton
H. W. MacGregor
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PERSONAL

A Guy's man requires Dental Assistant with view to associateship in busy long-established practice in pleasant South coast town. Good remuneration. Full clinical freedom. Box No. 14.

L.D.S., D.Orth. (Guy's-Eastman) available to undertake treatment on part-time/sessional basis in East Sussex. Please reply to Box No. 15.

BIRTHS

BANKS.—On 22nd June, 1965, in Victoria Ward, Guy's Hospital, to Diana (née Chorley) and Peter Banks, of 17, Beckenham Road, Beckenham, Kent, a daughter, Samantha Louise, a sister for David.

HARDY.—On 23rd March, 1965, at St. Theresa's, Wimbledon, S.W.19., to June, (née Horrocks, S.R.N., O.N.C.) and Dennis Hardy, L.D.S., R.C.S., a daughter, Ann Louise, sister for Charles and Graham.

WALDEN.—On 1st March, 1965, at Umtali, Rhodesia, to John and Sally Walden (née Edwards), a daughter, Susan.

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GUY'S HOSPITAL GAZETTE

FORTNIGHTLY ONE SHILLING VOLUME 79 NUMBER 2009

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EDITORS P. BOWDEN AND A. E. RAYNES

SPORTS CORRESPONDENT A. PROCTER

GUY'S HOSPITAL, LONDON

PASSIM

Confusion

The calm of the British Medical Association meeting at Swansea was dispelled by the fees-for-item-of-service motion, the requisite two-thirds members climbed onto the waggon and another ill-conceived threat exploded in the face of the Minister. The official leaders are further fettered in their discussions on the Charter and almost daily the position becomes more confused.

Some form of National Health Service is undoubtedly here to stay and the task at hand is to make it work to the greater satisfaction of the General Practitioner, who is most dissatisfied, and the patient. Its inauguration seventeen years ago became a political issue and the fears expressed at the time have mostly proven to be without foundation. "The majority, *faute de mieux,* will have to accept being posted to any practice which may be vacant without choice, introduction or option to transfer it if they should so wish", "doctors accepting service under the Act as it exists will have to watch their step, and do nothing to incur the displeasure of the powers that be, or else!" Passim expressed the considered opinion that doctors "cannot stay out of the scheme, or disagree with a portion of it, without the constant threat hanging over them that they can be dismissed, without appeal to the courts, at a moment's notice".

The increase in medical knowledge implemented through the National Health Service has lightened the burden of illness but much has been sacrificed by medical personnel and the conditions in many parts of the country are deplorable. Forty-one per cent of junior hospital staff in British hospitals are overseas graduates. The number of principals in practice fell by sixty-three in the second quarter of 1965 and the equivalent output of four medical schools emigrates yearly. It should be a salutory lesson to the Government to know that in recent months there has been practically a fifty per cent increase in the number of prescriptions, a figure that could cost the country fifty million pounds per annum. However, the profession has an obligation to itself to present a dignified and united front and to abstract itself from a morass of party politics and petty argument.

The patient is becoming more aware of his rights whereby certain fundamental functions should be performed by the doctor who ought to supply a basic medical care. There is bound to be abuse of any social service and when it is on a personal level it should be remembered that a man usually gets the respect he demands and the day is past when he receives undue discrimination merely because he is a doctor. Full surgeries and busy practices are a measure of the success of the general practitioner, the overtaxing of an overworked practitioner, is a measure of the failure of the Government to supply the needs of the demand which it has created.

If we are to utilise the advances of medical science there must be more doctors and more facilities to implement this new knowledge. It is time that we, as a country, sorted out our priorities and realised

that we cannot afford to have a finger in every pie and if we are to have a National Health Service the money can only be found by abandoning some other commitment.

Starched Heritage

Visitors to London are always delighted by the spectacle of its pageantry. Here the realm of history has left a little mark of splendour, a fragment of a fairy-tale world looking slightly absurd against the background of a modern city. Even the foreign faces around Horseguards Parade wear a whimsical expression which seems to match the bizarre dress of the soldiers.

A similar diversion into the past lingers on in hospitals in the nature of nurses' uniforms. The aesthetic of this uniform is one of nostalgia, for it is as far removed from fashion as it is from practicalness. For instance the cap, once of some doubtful purpose, has degenerated into a complicated vestigial device which defies gravity and looks many sizes too small. In design this uniform has yet to overcome the same problems that the first motor cars had in shaking off the form imposed by the hansom cabs.

A uniform should at least be practical while still fulfilling the functions of equality and prestige. That a more practical uniform could be designed cannot be denied. The new medical auxilliaries, the physiotherapists and radiologists, lacking the nurses' heirlooms, have adopted a simple and practical uniform. Suggestions of the nurses' heritage could easily be incorporated into more realistic design. If the nurses consider that their present uniform is necessary as a reminder of the past and their history, it might be appropriate for consultants to deport themselves in top hats and long coats and so complete the chocolate box.

Sebastapol was a long time ago.

Beaumont Quay

The warehouse on Beaumont Quay has been demolished and, with it the stone bearing the inscription, "This building and quay were erected by the Governors of Guy's Hospital in 1832. B. Harrison, Esq., Treasurer. The stones used in the quay formed part of London Bridge built about 1176. We hope the stone is in safe hands, for it was here that Sir William Gull's father worked and from nearby, Harrison's nephew a local clergyman, brought Gull to Harrison's notice, which led to his giving Gull a scholarship to Guy's.

GUY'S DIARY

ULY

Exhibition.		*Conjoined Twins.*
24th S.	10.00	Clinico-Pathological Meeting, held in the Clinical Theatre.
30th F.	1.00	Dr. SCOTT. Clinical Lecture.

DEAFNESS IN YOUNG CHILDREN

by Philip V. Reading

The grosser impairments of hearing in young children should be detected before the end of the first year. The physician must know the reactions of a normal baby to auditory stimuli at various ages.

From birth to the third month there is practically no response to soft sounds, though some authors believe that even at this tender age, the mother's voice close to the baby's head, may elicit a reaction. The response to a loud sound is the "startle reflex", an involuntary jerking of head, eyes and body, often followed by crying. This reflex persists till the third or fourth months, but its persistence to the sixth indicates delay in maturation. From the age of three months on the baby responds to sounds, even quiet stimuli, by turning his eyes towards the source; Kevin Murphy has conducted research into the maturation of this eye response. The reactions at the earliest age consist of a horizontal movement of the eyes towards the source, followed by a right angle turn in its direction, until the source is defined, like this——┐

a few simple words. By two, he should be constructing short phrases of two or more words, and from then onwards, he will be increasing both his vocabulary and the length of his sentences.

Deafness of varying degree is very common in infancy and childhood, but in the youngest children, it may not be possible to demonstrate any but the most profound deafness. The lesser defects will not be apparent during the first and second years. It is useful to classify the causes as arising during the pregnancy, during delivery, and in the first few months of life. The causative lesion may lie in the receptor and conductive mechanism of the meatus and middle ear, giving conductive deafness, in the cochlea, the auditory nerve and lower auditory nuclei, giving perceptive or sensori-neural deafness, or in the higher word hearing and word association centres in the cerebrum, giving the so-called central deafness. It is unfortunate that the deafness, arising from disorders before birth or at the time of birth, is usually either perceptive or central in origin, with the result that those babies who are born severely or totally deaf not only do not know what sound is, but are deprived of the means of acquiring that knowledge. If the loss is severe, rather than total, such sounds as they do hear, are distorted by reason of the cochlear defects, and may be difficult to interpret, or to associate with meaning, because there may be a co-existing defect of the higher centres. As may be imagined, a hearing aid may not prove of great help if there is considerable central defect, and, even if this is absent, the character of the cochlear lesion may make the amplification obtained from the aid intolerable to the child. On the other hand, post-natal deafness occurs in older children, who have been exposed to sound for a certain time before the onset of the deafness: further, they often have a conductive rather than a perceptive loss. The characteristic of conductive deafness is that the voice is muffled rather than distorted. These children may have a mental picture of the sound of words, derived from their memory before they became deaf, and on this they can build up their acquisition of speech. They also can hear well and without distortion with the help of a hearing aid.

An exhaustive list of the diseases responsible for deafness in young children is outside the scope of this short paper, but some of the commoner must be mentioned.

Pre-Natal Causes.

Genetic. The internal ear may completely fail to develop, or may do so in a distorted fashion. Seventy per cent of all cases of hereditary deafness are due to abnormal growth of the cochlear duct and its contents (Scheibe).

The facial appearance of the infant may be a guide to the clinician. In Waardenburg's syndrome, which is associated with percentive deafness, there is an outward shift of the inner canthi of the eyes, with an apparent broadening of the bridge of the nose. A white forelock, and irises of different colour are prominent features. Twenty per cent of children so distinguished will be found to suffer from perceptive deafness.

Plate 1. Waardenburg's Syndrome, by kind permission of Dr. Philip Evans.

Plate 2. Treacher-Collins Syndrome.

Another striking clinical picture is that of mandibulo-facial dysostosis (Treacher-Collins syndrome). The external ears are deformed and set low on the sides of the head, there is lack of development of the zygomatic bones, and bilateral notching of the outer third of each lower eyelid. The deformity can vary in severity, and one can sometimes see minimal changes in the parent's face, when the child is born with the full clinical picture. It is frequently associated with development anomalies in the external auditory meatus, or within the middle ear, and in consequence the hearing loss is conductive in type.

Viral diseases of the mother. Maternal rubella during the second and third months of pregnancy may produce a child with various defects, heart deformities, cataract, and perceptive deafness. The incidence and severity of the deafness vary with the virulence of the infecting virus, so that figures of the incidence of deafness are as high as 100 per cent in one series, as low as 3 per cent in another.

Maternal exposure to drugs. Streptomycin and quinine taken during the early months of pregnancy may damage the development of the foetal cochlea. Thalidomide may produce severe mutilation of the external ears, but few cases of proven cochlear deafness have been attributed to it.

Peri-Natal.

Kernicterus. Erythroblastosis foetalis may cause the infant to be dead at birth, or to die within a few hours. If he survives, jaundice develops, and as a result of the circulation of un-conjugated bilirubin in the blood, the basal nuclei and those in the hind brain become deeply strained with the pigment. One of the many disastrous sequels, should the infant survive, is a varying degree of deafness, perceptive and central in type, and associated with considerable mental retardation.

Low Birth Weight, and less commonly, *pre-maturity* are often found in the history of the deaf child.

Anoxia during, and after birth, together with a history of a difficult and traumatic delivery, may likewise be responsible for later deafness.

All babies who have been affected by any of the factors mentioned above are said to be at risk. This accounts for some 2 per 1,000 live births, but only half of these will be found to suffer from deafness.

Post-Natal.

Viral diseases, in the first few months of life, may cause damage to the internal ear; more commonly the naso-pharyngitis associated with the exanthemata leads to acute suppurative otitis media, and consequently the risk later of conductive deafness. Mumps may cause a sudden and complete loss of all inner ear function, luckily only in one ear, so that the resulting deafness may escape recognition for years.

Meningococcal meningitis may be accompanied by a meningococcal invasion of the internal ear, causing very severe or total deafness. Sometimes the parents of a deaf child may state that the onset followed a pyrexial illness, which was never definitely diagnosed, but was thought at the time to be pneumonia or meningitis. Tuberculous meningitis, treated by intra-thecal di-hydro-streptomycin, also causes severe deafness; after some weeks tinnitus is followed by gradually progressive deafness. This is caused partly by the toxic action of the drug on the end-organ, partly by tuberculous infiltration around the eighth nerve at the base of the brain.

Acute suppurative otitis media in children may lead to perforation of the tympanic membrane, and destruction of the ossicles, with consequent conductive deafness, which may, over the course of years, prove to be quite severe. Only rarely does the child have suppurative labyrinthitis as a complication of the middle ear suppuration, and suffer from total deafness as a sequel. In children from the age of three onwards, mild degrees of conductive deafness are caused by the accumulation of sticky fluid within the middle ear or by retraction of the tympanic membrane consequent upon obstruction of the Eustachian tube by naso-pharyngeal infections.

Diagnosis.

The physician attending a newly-born infant will be on the alert if he knows that, from the family history, from incidents during the pregnancy or during delivery, the child is likely to be at risk. He will repeatedly examine it, or send it to an otologist for that purpose, until the presence of hearing is clearly established by close observation of its reactions and by the evidence of its progress.

In a few months-old baby, unnatural quietness, failure to babble or to maintain babbling, and failure to respond by eye or head movements to sound stimuli are very significant. The mother may bring the baby to the doctor, expressing her anxiety about its hearing, and he would be most unwise to give her specious reassurance. Time-wasting procedures such as waiting till he is a year old, or two years old, or till he goes to nursery school are completely unjustified. In an older child, the complaint may be that he has ceased to babble, and does not turn his head in response to a sound on either side of him. If the deafness supervenes after the age of two years, what little speech has been attained is in danger of being lost. The deaf child of two and over will indicate his wishes to his mother by dragging her skirt and pointing to the object he desires.

Examination and observation of a child suspected of deafness may have to be repeated on many occasions, even to be sure of detecting the presence of hearing loss; no one is capable of expressing an authoritative and final opinion on the extent of the hearing loss until the child is three years or more, when audiometry can be done with some degree of accuracy; gross lesions may be suspected at a very early age.

The importance of being alert to detect deafness at the earliest possible moment is that the acquisition of auditory perception is greatest and most rapid during the first three years of life. During this period "the child, whether partially deafened or not, is ready to listen, and, if he is profoundly deaf, he must be made to want to listen".

The simple test that can be applied in very young infants is the elicitation of the startle reflex. A loud, sudden noise is made behind the child; if there is no twitch of the body or eyes, there is strong presumptive evidence of deafness. By the age of four months the startle reflex in a normally developing child is beginning to be inhibited, and the child is responding to a familiar noise, such as his mother's voice, by smiling and looking towards her face. By seven months, he will respond to any noise, familiar or unfamiliar, by turning his head and eyes, the startle reflex should have completely disappeared, and, if it persists, one would know that there was delay in maturation, and suggestions of a central lesion would raise themselves.

In children of eighteen months, the parent's complaint will probably be that the child does not talk; but it is relatively easy at this age to demonstrate whether the child responds to sounds or not. If he does, then increasingly the doubt arises whether the failure to talk arises from simple delayed maturation, or from mental retardation. Children suffering from multiple handicaps, and autistic children, both offer very great difficulties to the diagnostician.

While it is one thing to be able to show that the young child responds to sounds, it is quite another to be able to define the degree of hearing loss either in terms of frequencies or intensity. A full evaluation must wait until he is old enough, about three years old in most instances, to respond to play conditioning. In this he is taught to perform a certain action, e.g., place a ball in a cup, every time he hears an auditory stimulus. This may be the human voice in various degrees of loudness or softness, or pure tones emitted by the audiometer.

Should a child be found to be suffering from a severe loss of hearing at the age of twelve months, or before, the mother must be made to understand that he has lost a whole year, during which, had he enjoyed normal hearing, he would have been constantly exposed to auditory stimuli, and would have been learning to associate them mentally with the sensations, the appreciation of texture, taste, look, etc. The defective child has a year's leeway to make up, and he must be helped to receive auditory stimulation in a more intensive and a more constant manner than the normal child. The mother must be made to realise that the child can be helped to talk, and to make the most of his hearing, largely as a result of her own endeavour. She must be encouraged and heartened by frequent counselling to face the difficulties ahead. She must talk to him constantly, clearly and loudly, close to his ear. He will be fitted with a binaural hearing aid, which he should wear during all his waking hours. The child must be exposed to the human voice at an intensity at which he can hear, if necessary with the help of the aid, and for long periods. It is exhausting work, and the right person to do it is the mother, no one else can do it so well. It is heart-breaking work, because for months the baby may make no attempt to phonate at all, and all seems to be in vain. But, during this period, he is busily engaged in receiving the auditory stimuli, and building up his memory patterns and associations of sounds.

As soon as he is old enough, he should attend a day nursery, where he will be exposed to an even greater intensity of speech from the other children. From this age, his progress will dictate the further shape his education will take. If the delay in talking were only slow maturation, as is so frequently the case, the exposure to other children will start him talking freely; if he has an organic defect in hearing, he may have made so much progress as a result of training of the hearing that he will be able to attend an ordinary school, still wearing an aid if his hearing is not good enough to allow him to benefit from teaching in open class without. If the hearing defect is too great to permit him to learn in competition with normally hearing children, he will do better at a school for the hard of hearing. Only in the exceptional case, where complete loss of hearing is present, or a severe, partial loss is accompanied by other handicaps, need one fear that the child will not be equipped for making his way in adult life.

British Dental Students Association and International Association of Dental Students Combined Congress 1956

I should be obliged if I might have the opportunity of informing your readers of the British Dental Students' Association and International Association of Dental Students' Combined Congress, which is to be held at Guy's between the 14th August and 21st of August.

About two hundred foreign students are expected to attend, from Denmark, Sweden, Norway, Holland, Germany, Yugoslavia, Israel, Iceland, Czechoslovakia and Finland. The organizing committee would like to apologise for any inconvenience that may be caused to those of your readers who may be at the hospital at the time. However, it is hoped that people will take advantage of this excellent opportunity to meet and talk with students of other countries.

There are to be lectures, demonstrations and discussions which will be open to Guy's people. Further details of these will be published on the various notice boards around the hospital.

EYE DISORDERS IN HANDICAPPED CHILDREN

PETER A. GARDINER

The vision that almost every healthy adult uses in the prime of life is settled before hand by events and processes occurring during his childhood (or before) and his adolescence. It is therefore in the interests of everybody's activities that all possible efforts are made to trace the causes of defective vision, to discover disorders early in their existence and to follow up discovery with immediate appropriate treatment where it is possible. Where causes are not known, where methods of early detection are inefficient or dilatory and where treatment is ineffective are the places where intense research should be actively prosecuted. As an example, we may consider the children (4 per cent of the population) who grow up with only one useful eye. The causes of uniocular amblyopia are not properly known. Heredity yes, but many cases occur where heredity gives no lead. Squints yes, but not all patients with squints have amblyopia and not all amblyopic eyes squint—and what causes the squint? Anisometropia, where the refraction in the two eyes differs greatly so that one is preferred, yes—but what causes the anisometropia?

The early discovery of a lesion traditionally depends on the close study of symptomatology but in the absence of a squint unilateral amblyopia has none in a young child or infant. Because of this many cases are missed in the early years of life. Various consequences grow from the failure to detect a defect at this age. Firstly, the condition cannot be treated at the most favourable age, secondly, the sensory input is defective during the formative years and thirdly, the child becomes conditioned to this faulty mechanism, compensating though inadequately in many ways, so that when measures are eventually taken the conditioning has to be undone and visual acuity built up perhaps from scratch, maybe many years after nature considered it essential for its development, and with ultimate failure. In this particular example school age is usually too late.

I have used the example of unilateral amblyopia because it is the most commonly missed defect amongst young normal children but it is not the most severe visual handicap that can occur without symptoms. Every now and again children with quite gross defects of vision in both eyes, either for near or distance or both, arrive at school without any suspicion on the part of their parents that there is anything wrong. If such a child is missed at the school medical or proves difficult to examine, it may be a year or two more before these defects

are discovered. Though it is possible to make up for lost time in some cases at these later ages, it is clearly wrong that their information about the world should have been faulty so long and that their opportunities to learn basic visual skills in the most formative years be restricted by the default or ignorance of their elders.

If this is the situation in normal children how does it apply in the handicapped, by which I mean children with a constitutional disability of body or mind which limits his normal development and function?

Firstly, visual defects are much more common amongst handicapped children. Thus in a school for those children, 60 per cent of the brain-damaged (mostly spastic and athetoid) had an eye lesion. About 40 per cent of spastic children squint. Amongst the other handicapped children 16 per cent squinted, still a much higher figure than in the normal population.

Twenty-eight per cent of the brain-damaged were amblyopic (4 per cent in normal children), 24 per cent had difficulty in reading small print and 18 per cent of the other handicapped children had similar difficulty.

It is well known that hypermetropia is associated with squints and if severe enough with difficulty with near vision. Not only are more brain-damaged children hypermetropic than normal children, but also three times as many of the hypermetropic children squint amongst the brain-damaged, compared with other physically handicapped children. It might be thought that these examples are to be expected because squinting is a neuromuscular disorder.

However, if we consider children without brain damage with congenital heart disease of school age we find that 22 per cent of children with Fallot's tetralogy squint and no fewer than 40 per cent of their eyes are to some extent amblyopic. Sixty per cent had an eye lesion of some sort. In about 100 consecutive children with congenital heart disease of all sorts going through hospital, some 20 per cent of the eyes were amblyopic to some extent and 12 per cent squinted. Thirty per cent had an eye lesion of some sort. There is little doubt that if more research into such groups of children were carried out we should find interesting and unsuspected associations of visual defects with somatic disease.

Secondly, we have seen that in normal children many cases of visual defect occurring in early childhood are missed until the school medical. It is because visual defects in older children are not a source of complaint that eyesight tests are performed as a matter of routine throughout their school career. Amongst handicapped children not only is there a higher incidence of defects but much more difficulty in making the diagnosis. It is still quite common for such children of school age to be recorded as "unable to test" because of, say, speech difficulties, difficulties in understanding the test, or in manipulating the material. More of these children are away from school on the day of the test and follow-up is more often inadequate. Such symptoms as there may be are put down to the handicap. As an example, I know of a doctor's child sent to a school for maladjusted children

who was found at the age of seven to have cataracts. Then there was the case of a child with Down's syndrome, of "exceptional friendliness and interest". This because she always broke from her desk to go up to the teacher and investigate her equipment. She was found to be a high myope and her motives had been misinterpreted. She merely wanted to see what was going on and being talked about. There are numerous examples at all schools for the physically handicapped and the mentally subnormal, of undiscovered and unsuspected visual defects and nobody knows how many amongst pre-school children in these categories because no screening is performed at earlier ages. The figures available for one such school show that out of 39 children with abnormal eyes 19 (50 per cent) were either receiving inadequate treatment or were undiagnosed, or both. In the same age group (7-15) a survey was carried out of children with cerebral palsy referred because of "perceptual difficulties" arising out of intelligence testing. This was carried out at two teaching hospitals. Nine out of 33 (30 per cent) had eye lesions which had been overlooked.

Amongst the 100 or so children with congenital heart disease examined at hospital, 36 had eye lesions. Of these 36, 22 were previously undiscovered, 9 of the latter having moderate or severe defects with a visual acuity of 6/18 or worse, four of them in both eyes. Virtually all these defects were congenital or present from infancy. Two of the overlooked were squinting.

This failure to diagnose eye defects in these children would not be tolerated amongst healthy children and occurs partly because of the difficulties already mentioned, and partly because the concern for the health of the child pushes such minor (!) considerations as its sight into the background. Another deterrent to discovery is the attitude that "the child has enough to put up with".

Just how misguided this attitude is makes my third point that the child handicapped in other ways may be more likely to benefit from good sight developed earlier than a normal child. Why should such a child's sensory input be limited? If any young child's vision is so blurred that he cannot see his mother smile it is a severe emotional deprivation but for a child already handicapped in other ways this is surely a burden he could well be spared. Such a child is likely to become withdrawn emotionally from this alone, and infant backwardness is a feature of children with poor sight—only too easily put down to the mental or physical handicap in those so afflicted in addition. In normal children the provision of glasses sometimes makes an astonishing difference to its place in form. In handicapped children who learn not only academically but about their environment and about how to develop their various skills at a slower pace than normal children, it seems logical that provision should be made for them to see well from the youngest age possible in the hopes of removing one obstacle to learning about the world. This applies, I think, as a matter of obvious principle but the following case makes it clear. This was a mildly athetoid child who had no speech and was deemed ineducable. At the age of 6 she was put in a junior training centre. At the age of 9 she was discovered to be deaf and was transferred to

a school for the physically handicapped and given a special teacher. At the age of 11, though this could have been discovered by appropriate methods at any age before, she was found to be so hypermetropic that lip reading and book reading were out of the question. Immediately she was given glasses her speech improved, her "hearing" improved, communication became a joy instead of an impossibility and she can now read and type.

In the case of mentally handicapped children we cannot necessarily get sufficient co-operation to perform normal testing techniques of their visual acuity and in any case their interpretation may be so defective that it may not signify whether images are clear or blurred. However, in one school for mentally defective children more than 50 per cent of the children ordered glasses because of refractive errors were wearing them after three months. Either they appreciated their improved vision or else they fancied themselves in glasses. Some of these children become employable as adults and one of the favoured occupations for them is to make small parts for computers. This requires excellent visual acuity for near vision which many would fail to attain without glasses. The temptation would be to ascribe clumsiness to mental inability in these cases.

The case was made many years ago for normal children to have routine visual acuity tests at intervals during their school years. This is standard practice by all local authorities. I hope that I have made the case that handicapped children, in whom defects are more common, more difficult to diagnose and equally, if not more, important to treat than in normal children, constitute a special group of children with an increased risk warranting special efforts and special measures to detect defects early. It would be a great advantage if we could be more precise than this. For instance, work which is still incomplete suggests that cardiac lesions of the "shunt" variety do not carry much more risk than normal, whereas Fallot's tetralogy carries a very high rate. This type of risk analysis requires considerable research not only to establish the categories of children involved but also possible common ante-natal causes which increase risk. We know that rubella causes congenital cardiac lesions and cataracts but cataracts are only one of many eye lesions causing defective vision and not by any means the commonest in children. We know that excessive oxygen therapy at or near birth causes retrolental fibroplasia and that premature children more often need oxygen, more often suffer brain damage and have a high incidence of visual disorder. In cases of uniocular retrolental fibroplasia the other eye is frequently highly myopic. Here again there are predisposing factors increasing the risk. There are many other potential factors such as any pregnancy disorder, multiple pregnancy, metabolic diseases and so on, which increase the risk of causing physical handicap and/or visual lesion.

I have not specified particular lesions partly because the whole range of all types of visual disorder appears to occur in handicapped children, without any specific eye lesion being associated with a specific somatic lesion, but mainly because the cause of the defect should be diagnosed and treated early in life.

Having recognised this need, and taking into consideration our methods of dealing with normal children, it seems to me that this early diagnosis, usually in the absence of symptoms, can only be made by setting up special screening clinics for young children such as the handicapped who are known to have an increased risk of visual defect and an increased need for first class vision. Such clinics have yet to be set up but in their absence any doctor if he sends *all* his cases of brain damage to an ophthalmologist at the optimum age, which is two to three, will be right more often than wrong if he says he suspects an eye lesion—even without looking at the child. In the presence of symptoms, referral should be earlier, of course.

One can only hope that research will identify the groups at risk more thoroughly, which should give some leads to possible causes and provide clues as to better methods of prevention, diagnosis, and successful treatment.

CORRESPONDENCE

44th Parachute Field Ambulance

SIR,—The 44th Parachute Field Ambulance is the only medical airborne unit, other than the regular 23rd Parachute Field Ambulance, and we have a constant requirement for recruits to replace those who move away and can no longer manage the attendances they would like. The training both professionally and in all-round other respects is first rate, as befits a unit where self-reliance and individual skill and confidence is required to be of the highest order, and it makes a most interesting and worthwhile part-time occupation.

We would be pleased to see anybody interested any Wednesday evening when there is training from 8 p.m. to 10 p.m., and a chance of a talk over refreshments afterwards. A look in entails no obligation to join!

Yours, etc.,

MAJOR D. L. HAMBLEN, R.A.M.C./TA.

44th Parachute Field Ambulance, R.A.M.C. (T.A.),
T.A. Centre,
2, Jamaica Road,
Bermondsey,
London, S.E.16.

Medical Practice and the Magna Carta

IR,—Your article No. 2008 by R. K. Allday is so excellent and clearly thought out that I wish it could have a wider audience, especially as sanity and clarity are sadly lacking at this time.

Yours, etc.,

JOHN BUCKMASTER.

11, Windlesham Avenue,
Seven Dials,
Brighton 1.

In His Own Speek

DEAR FAVA,

I am having a grate tyme as a murdical stoogent at Guys Hospital. My digs is at Broccoli, a shawt train ride from the Burrow. It is very nice and my only trubble is my lanlayby who leaves her teef in my mug every nite.

All day I am on the warbles seeing my pashuns, and I tak blud from their alms, leaving big broozes. They call me "My stoogent." One pashun is an utmost complan case. His illmesses inclued bronickal askma, gastricken stomache, yell-O jaundis and a grate big scroples bag. The consultit has maid a slic diagnoble. He ses the pashun hasgott sickogenic inflexion. He is being wotchered klept on a very xpensieve drag called Clorempynenicals.

I am going out wiv a little nurzzle who walks on the sam warble that I am on. She tels me all about blanket barse and the warble sister, but when I get her orf sutch sobjects she is very cooperable.

Guys Hospitable is very ould as can be scene by the mosaches on the floors, and the luly farcade at the frunt near the maim gaits. I often thinc it was a grate acheatment to get here from my ould skool.

O, my beep is going, so I will have to clothes and wrung to the warble. The house fizzishun probable wants me to do a yewrhinanalicis.

Yor luving sun,

FRANK

Retirement of Miss D. L. Farmer

SIR,—Guy's graduates, and particularly those who qualified in Dental Surgery, will be sorry to hear of the impending retirement of Miss D. L. Farmer after working in the Medical School Office for 22 years.

The welfare and progress of students has always been one of her major concerns, and I know of many occasions on which she has gone out of her way to assist them in various aspects of their training. Her kind and sympathetic advice has always been appreciated and she will be greatly missed from "the Office."

A presentation is being organised, and I shall be pleased to receive donations from the many Guy's graduates who will wish, on the occasion of her retirement, to show their appreciation of all the help she has given them. All cheques will be acknowledged. They should be made payable to Guy's Hospital Medical School and sent to me, care of the Medical School Office, preferably before the end of August.

Yours, etc.,

F. S. WARNER,

Dean of Dental Studies.

Guy's Hospital,
London, S.E.1.

Marriage Guidance Council

SIR,—A marriage counsellor has sent me a copy of the recent issue of the *Gazette* which mentions Marriage Guidance Councils on page 339.

It is quite correct to say that all marriage counselling interviews are confidential, and that it would not be possible for a medical student to be present in the room when the counselling interview was going on. At the same time, I know that the London Marriage Guidance Council or, indeed, any representative from this office would be only too happy to speak to medical students about the kind of work we do.

Yours, etc.,

G. P. SANCTUARY, *National Secretary.*

The National Marriage Guidance Council.

WHAT IS MARFAN'S SYNDROME ?

by Robert Oxlade

Hereditary, Familial, Congenital, Haemorrhagic Nephritis and Marfan's Syndrome; an examination of the literature with regard to common aspects of these diseases.

The entity "familial congenital albuminuria" seems first to have been described by A. Howship Dickinson (1) in 1875; several members of one family, from a very early age, were noticed with albumin in their urine, and it was with such a family in mind that L. Guthrie (2) described, in 1902, under the title "Idiopathic Familial Haematuria", the phenomenon of hereditary familial congenital haemorrhagic nephritis. In the family Guthrie describes, a typical example of this disease is furnished by an account of a boy who, normally having albuminuria and microscopic haematuria, would show every two or three months attacks of gross haematuria. According to the boy's mother, he would become ill during the attack, which lasted for about a week, and then he would be restless and sometimes scream while sleeping; before the onset of the attack he would become enuretic and show frequency of micturition. Such a disorder was common in this particular family, and was frequently precipitated by the eating of blackcurrants or the drinking of port wine. (This unusual family must have achieved considerable fame in medical circles even at that time, for the estimations of urinary albumin were performed by Archibald Garrod himself.)

This same family was followed up in 1912 and again in 1923 by Arthur Hurst (or Hertz as he was in 1912, refs. 3 and 4) who renamed the syndrome "Hereditary, familial, congenital, haemorrhagic nephritis". Hurst's article establishes with certainty the five named aspects of this disease, but unfortunately he leaves no hint whatever of any other physical or physiological details concerning this family. Fortunately, however, A. C. Alport (5) reported, in 1927, once more upon this same remarkable family. Alport, in referring to Dickinson's family of 1875, draws the distinction that Hurst's family differs by virtue of the variable extent of the albuminuria and haematuria, that these were liable to paroxysmal exacerbations, often with influenzal-like symptoms, and that the disease often progressed to be accompanied in its later stages by hypertension and cardiovascular changes (which he does not specify) and often terminated in uremia. He noted that in this family of Hurst's oedema occurred during the later stages of the disease; and in particular, one boy described in detail is noted as being "tall for his age". Alport makes two more significant observations; firstly, that the family was not seriously worried about its haematuria, but it was worried by deafness, which afflicted some of

those without renal disease, and many of those with. And secondly, that in this family it was the males who were most seriously affected with both renal disorder and deafness, and that they did not generally survive after early adult life, while the females had both deafness and occasional haematuria, and survived into old age. Again, the family must have been in the medical limelight, for two of its members travelled back from America to be investigated, and for several Alexander Fleming prepared special vaccines to try to overcome the urinary tract infections from which they suffered.

Not until 1950 did Hawkins and Smith (6) describe another family in which renal dysplasia was associated with more obscure multiple hereditary anomalies which they list, including iliac horns. The renal disorder here resulted in a picture indistinguishable from chronic glomerular nephritis, with chronic albuminuria and casts of all kinds, and occasional red cells. The anomalies associated with renal disorder in this family included pigeon chest, thoracic kyphosis, congenital cataract, small patellae, arthrodysplasia, pes planus, stiff lumber spine, cervical ribs, and half-absent thumb nails. It is interesting that all these defects should have been found in at least several members of the family, because in many cases they are the same, or same sort of defects as are found in Marfan's syndrome, which I shall describe later.

It would be of interest to know whether the relatives of the family of Guthrie and Hurst who came to England in 1927 ever went back to America again. At any rate, Schafer and Scriver (7) described a family in Boston in 1962, who suffered from an association of haematuria, eighth nerve deafness, mental disorders and seizures, and in some cases deformities of the urinary tract. They were able to measure the proline levels in the plasma, and found that members of this family were distinguished by a raised proline level. They called their report "Familial Hyperprolinemia". They noted that despite the consequent loss of proline and hydroxyproline in the urine of these people, wound healing and plasma hydroxyproline levels were both normal. This should suggest, I think, that probably proline is appearing in excess in the plasma as the result of abnormal rate of breakdown of collagen.

At this point I would like to turn to Marfan's syndrome, and trace briefly the development of this concept to the present day. A. B. Marfan described in 1896 (8) a girl of five who had long, thin extremities—"dolichostenomelia"—and who had weak and hypotonic musculature. The same child was observed again in 1902 in Paris (9) by which time she was markedly kyphoscoliotic. Later in the same year, Achard (10) described the long, slender fingers and coined the term arachnodactyly, which is generally associated with the syndrome to-day. He also noted the possibility of a familial tendency about it, as the girl's parents also had long, thin hands and fingers. Between that time and 1960, when Sinclair, Kitchin and Turner (11) reviewed the cases described until that time, no less than approximately eighty

structural and functional defects had become associated with the syndrome. It would be tedious to list these here; many of them, however, seem to arise from a basic defect of the collagen fibres. The collagen is somehow either formed defective, or else is destroyed in the body more readily than normal. As a result, ligaments are weak; for example, the suspensory ligament of the lens collapses, and the resulting ectopia lentis is often the first indication of a Marfan type deformity. Joints are weak and tendons are lax. The vertebral column becomes deformed, being either kyphotic or scoliotic. Individual vertebrae become deformed. In the major blood vessels, the media breaks down under strain, and the aorta dilates or dissecting aneurysms form. Some authors claim this destruction is the same as that described by Erdheim (12) as "cystic medial necrosis". A similar weakness of collagen in the heart gives rise to valve lesions.

The exact fault in the biochemistry of collagen is still not clearly known. The lesions of skeletal deformation and aneurysms of the large arteries can be mimicked experimentally by inducing lathyrism in rats by feeding them with the seeds of Lathyrus odoratus (for refs. 13). The isolated toxic substance is beta-amino-propionitrile, and what probably happens (Tanzer and Gross 1964) in the case of lathyritic poisoning is that the primary structure of collagen is altered by amino acid substitution, or by alteration of the amino acid sequence, and that the secondary structure changes as a result of this so that the collagen fibrils which form extracellularly have their cross linkages altered. This may explain the alteration of the solubility properties of collagen formed under the influence of beta-amino-propionitrile. In lathyrus poisoning, the weakened, abnormally soluble collagen disintegrates after a shorter life-span than the normal collagen and its breakdown products, including proline, cause hyperprolinaemia and prolinuria. If an enzyme defect occurred at the same point in the synthetic pathway of collagen in victims of Marfan's syndrome, the same consequences would emerge—of weakened structures, and subsequent hyperprolinaemia and prolinuria (and hydroxyprolinuria, since the excess proline blocks the renal tubular reabsorption mechanism for hydroxyproline). Such an hypothesis has received some experimental justification from the results of Jones and others 1964 (15) who investigated the levels of urinary excretion of these two amino acids in a group of Marfan's syndrome patients, and in a large group of controls. Their results show that while results for the adolescent Marfan's range from 13-18 years were too variable for significant comparison, the younger age-group was consistently much above that of the normal group and the adult range of Marfan's compared to normal match controls was raised by several hundred per cent.

Which brings me back to Schafer and Sciver's family with hyperprolinemia and renal anomalies (7); can these be related to the Marfan type syndrome? While Jones et al. have shown that all Marfan's syndrome patients which they examined had hyperprolinemia, they did not show that all hyperprolinemia was Marfan's syndrome. For a closer investigation of the associated renal defects found in cases of

Marfan's syndrome, we can look at the survey by Lavinia Loughridge in 1959 (16). She found, indeed, that many of the Marfan's syndrome patients she examined had disorders of renal function—proteinuria, pyuria, and pyelonephritis. Abnormalities detected by intravenous pyelography included bilateral clubbing of the calyces, ureteric dilatation, ectopic kidneys, double kidneys or double ureters. Frequent findings among the histories included nocturia, enuresis, pain in right loin, dysuria, hypertension. Some of these patients had presented with back pains, joint pains, hip pains, or indeed vague undifferentiated pains all over the body; one such as the last mentioned had been diagnosed as "psychoneurotic".

With such scattered material—historically and geographically—as these rare familial collections of anomalies of structure and function, it would be impossible to prove that Hurst's Hereditary Congenital Familial Hæmorrhagic nephritis on the one hand and Marfan's syndrome on the other were related by features common to both and that some families showed parts of one disorder together with part of another. It would not even be a useful exercise, because there must be many genes involved to cause such a multiplicity of abnormality, and it is probably preferable to be aware of the fact that long fingers point to many things beyond a Gothic palate, than to define syndromes in terms of the two most blatant things to be seen. In conclusion, I should like to ask the question, "Does this really matter—three families in a hundred years—perhaps three of the obscurest collection of complaints ever recorded?" The answer must be yes; not only because of the persistent nature of intellectual curiosity, but because it is necessary to preserve hologNosiology (*Lancet* 1959, i 625) in the interests of patients, as I hope reference to the following case will show. All the features mentioned, unless other references are quoted, will be found described in association with other cases of Marfan's syndrome in the review by Sinclair et al, (11).

On the 2nd January his year, M.A., a man of 20 years, presented very late at night complaining of inability to pass urine normally, and lower abdominal pain. During the past year he had had episodes of haematuria and dysuria. On examination, he was a tall, droopy man, with extremely long, very thin fingers. He had a long face, large ears, and wore glasses to correct myopia. He also had a squint. The arms were long and the legs long and thin. He complained that his legs had swollen during the previous year from time to time, and "gone black and blue". The mouth was moist, and gingivitis was marked. The abdomen was diffusely painful. The scrotum was empty but tender. The prostate was enlarged and acutely tender. Pulse was 90 and BP 150/90. On previous admissions he had been treated with steroids for the undescended testicles, for which orchidopexy was later formed in 1956; at operation the testes were found to be atrophic (17, 18). He had been admitted several times since then when a diagnosis of pyelonephritis was made. He had presented previously complaining of back pain; radiographs showed some

sclerosis of the sacro-iliac joint. The same radiographs also showed asymmetry of the pelvis, and a small lumbar rib on the first lumbar vertabra. On one of these earlier admissions, a high arched palate had been noted, and a depression deformity of the upper part of the chest, and a dorsal lumber scoliosis. His metacarpal index (which I have calculated from a radiograph of 1959) was 8.45 at the age of 14. At one time a pulmonary systolic murmur had been noted. Previously, many of his pains had been considered "hypochondriacal", and he had been under psychiatric supervision for some time. The one feature which doesn't actually seem to have been previously recorded is urethral meatal stricture, for which he underwent a corrective operation in 1956. As a boy he had never played games at school. In his family history, his mother is hypertensive, his father has varicose ulceration on his legs, and a cousin has had rheumatic fever.

Unfortunately, his stay in hospital was very brief, and further examination might reveal more features still. To confirm a diagnosis of Marfan's syndrome would be important, because renal lesions in his mother or father might be available to treatment if found. For his own sake, the patient should be examined from time to time to safeguard against the development of an aortic aneurysm, a frequent cause of death in Marfan's syndrome. If this patient should present again, armed with foreknowledge, perhaps we could measure his urinary hydroxyproline and proline output. But only a rash researcher would try the effects of blackcurrants!

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SPORT

ATHLETICS

Two members of the hospital team competed in the A.A.A. Championships. On the Friday evening, Ian Morgan beat the British Universities champion to win his heat of the 440 yards hurdles in 54.8 seconds. The conditions for the final the following day were far from ideal as there had been a great deal of rain. The international line up for the final included the world record holder and Olympic champion, Rex Cawley, of U.S.A., John Cooper, the Olympic silver medallist, and the Norwegian champion. In this distinguished company, Morgan did well to stay with the leaders for three quarters of the race, and finished strongly to take fourth place in his best ever time of 53.5 secs., Cawley winning in 50.9. R. Morris cleared 6ft. 2ins. to place 9th in the high jump final.

Morgan and Morris have been selected to represent British Universities against the A.A.A. and Combined Services at Portsmouth on August 7th.

UNITED HOSPITALS' SWIMMING CHAMPIONSHIPS

For the third year running Guy's won these Championships by a wide margin. With almost the same team as last year, Guy's were favourites, and with the late withdrawal of the most dangerous St. Mary's swimmer through illness, the opposition were left floating.

Roddy Jones retained his freestyle and backstroke championships in new record times. For this he shared—for the second year running—the d'Abreu Cup for the best gala performance.

The rest of the team gained points in all the other events except the men's diving, in which the two Guy's competitors gained more laughter than points. B. Valentine swam well to come second in both the butterfly and the breaststroke. A. Forbes, swimming against strong opposition, batted into third place. D. Anderson proved his fitness by swimming ½-mile freestyle and then 100 yards backstroke immediately after, swimming both against the backwash in the outside lane. The relay teams won by ¼-length by superior swimming down the order in both relays.

Mention must also be made of the Ladies' team, which won the Ladies' Championship. R. Lennon retained her breaststroke championship, also coming fourth in the backstroke. Janet Higgs again won the diving—perhaps making up for the failure of the men. The other girls swimming, R. Sasson, J. Abels, and E. Cotton, all gained places in individual events, and together won one relay and came second in the other.

Guy's Results.

Men:

440 yards Freestyle—5th, D. Anderson.
100 yards Butterfly—2nd, B. Valentine; 4th, D. Barnes.
100 yards Freestyle—1st, R. Jones, 54.8 secs. (Record); 3rd, A. Forbes.
100 yards Breaststroke—2nd, B. Valentine; 4th, J. Holland.
100 yards Backstroke—1st, R. Jones, 62 secs. (Record).
4 x 1 Medley Relay—1st. (R. Jones, B. Valentine, A. Forbes, D. Barnes.)
6 x 1 Freestyle Relay—1st. (R. Jones, B. Valentine, A. Forbes, D. Barnes, J. Holland, D. Anderson.)

Ladies:

1 length Freestyle—2nd, R. Sasson; 4th, J. Abels.
1 length Backstroke—4th, R. Lennon; 5th, R.Sasson.
1 length Breaststroke—1st, R. Lennon; 3rd, J. Abels.
4 x 1 Medley Relay—1st, Guy's.
4 x 1 Freestyle Relay—2nd, Guy's.
Diving—1st, J. Higgs.

Final Results.

Men: Guy's, 48 pts.; Mary's, 31 pts; London, and Bart's, 18 pts.
Ladies: Guy's, 40 pts.; London, 36 pts,; King's, 31 pts.

J. HOLLAND

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the following appointments in the **Department of Conservative Dental Surgery,** with duties commencing 1st October, 1965:

Full-time Registrar;

Registrar, to attend on five sessions per week for the period 1st October, 1965, to 31st July, 1966.

Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, London, S.E.1, not later than **Monday, 16th August, 1965.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Registrar in Ophthalmology,** with attendance on two sessions a week, commencing as soon as possible. Forms of application are available from the Superintendent, Guy's Hospital, S.E.1, and should be returned to him not later than **31st July, 1965.**

EVELINA CHILDREN'S HOSPITAL OF GUY'S HOSPITAL, SOUTHWARK BRIDGE ROAD, S.E.1.

Applications are invited for two posts of **resident Paediatric House Officer** (with casualty duties) for six months from 1st October and 1st December, 1965. The appointments are recognised for the D.C.H. and consist of four months medicine and two months surgery. Candidates must be registered practitioners and should apply giving age, nationality, qualifications (with dates), and copies of three recent testimonials to the Hospital Secretary by first post on Monday, 23rd August, next.

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Diploma in Orthodontics

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UNIVERSITY OF CAMBRIDGE

Final M.B. Examination, Easter, 1965

Part 1. Pathology and Pharmacology

J. K. Beattie
G. H. Pettiford
C. R. Sheard

Part 2. Principles and practice of physic

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D. R. Bevan*
T. J. R. Bruce*
Elizabeth A. Cosgrove*
D. J. Ewing*
K. E. Haynes*
A. M. Morris*
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D. R. J. Quickenden
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J. D. Rogers*
C. R. Sheard*
A. R. M. Upton*
N. W. D. Walshaw*
G. F. Wearne*

Part 2. Principles and Practice of Surgery

J. K. Beattie*
D. R. Bevan*
T. J. R. Burce*
Elizabeth A. Cosgrove*
D. J. Ewing*
K. E. Haynes*
A. M. Morris*
G. H. Pettiford*
G. A. Pettitt*
J. D. Rogers* **
C. R. Sheard
A. R. M. Upton*
N. W. D. Walshaw*
G. F. Wearne*

Part 3. Midwifery and Gynaecology

J. K. Beattie*
D. R. Bevan*
T. J. R. Bruce*
Elizabeth A. Cosgrove*
D. J. Ewing*
K. E. Haynes*
A. M. Morris*
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**Distinction

Primary Fellowship

R. H. Jago
B. J. Main
K. M. Pagliero
A. J. Robson
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BIRTHS

LILLICRAP.—On 22nd June, 1965, at Johns Hopkins Hospital, Baltimore, U.S.A., to Gwyneth (née Roberts) and David Lillicrap, a son, Peter Andrew, a brother for Stephen, Susan, and Richard.

McILLERON.—On 6th July, 1965, to Jill (née Joslin, B.D.S.) and Geoffrey McIlleron, of 4, Wilpet Court, 48, Ellis St., Bellevue, Johannesburg, a daughter.

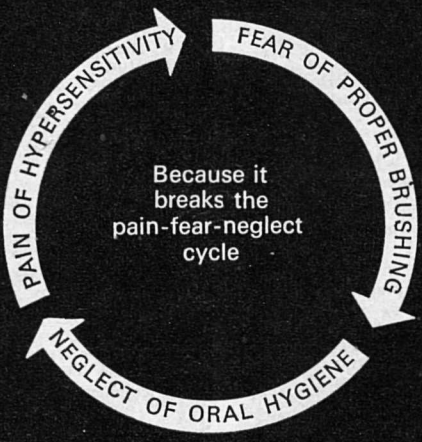
WINCHESTER.—On 8th May, in Salisbury, Rhodesia, to Athele (née Beatson) and Alan Winchester, a daughter, Deborah Jane.

DEATHS

LLOYD.—Edgar Allan Lloyd, L.D.S., R.C.S., aged 75, on 21st June, 1965, at his home, Three Hollies, Brilley, Hereford.

in adjunctive treatment of hypersensitivity:

Sensodyne first

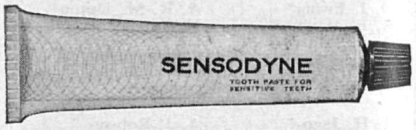

PAIN OF HYPERSENSITIVITY
FEAR OF PROPER BRUSHING
NEGLECT OF ORAL HYGIENE
Because it breaks the pain-fear-neglect cycle

First in professional acceptance . . . Sensodyne is the *strontium-ion* breakthrough in hypersensitivity therapy . . . breaks the pain—fear—neglect cycle by desensitizing while promoting proper toothbrushing habits. Sensodyne's outstanding effectiveness and safety have been confirmed in four independent clinical studies and thousands of private practices.

First in patient satisfaction . . . relief grows as therapy continues. Patients like *and use* refreshing Sensodyne. They gladly "brush more . . . to hurt less", on a twice-daily continuing basis.

The therapy of choice . . . when apparently normal teeth are sensitive to heat, cold, sweets, acids or touch * the sensitive tooth neck is exposed through surgery or recession * dentine and cementum are exposed through abrasion, attrition or erosion.

Clinical studies on Sensodyne reported in the dental literature (reprints available):
1. Cohen, A.: Oral Surg., Oral Med., Oral Path. 14:1046–52 (Sept.) 1961. 2. Skurnik, N.: J. Periodont. 34:183–185 (March) 1963. 3. Zelman, H. and Hillyer, C. E.: New York J. Dent 33:259–262 (Aug-Sept.) 1963. 4. Ross, M.: J. Periodont. 32:49–53 (Jan.) 1961.



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PASSIM

Prevention or Promotion

Road accidents account for one hundred thousand persons killed or injured in this country every year. The figures are published like cricket scores every bank holiday and dutifully compared with last season's averages along with the weather. For the rest of the time the public hears little to disturb them except for the feeble propaganda of the police and something about drinking and driving.

The councils and laboratories that have been established to investigate this tragic waste of life have produced recommendations almost as profusely as the accident rate itself. Some of these have been simple and one might have thought reasonable to enforce, but legislation has curiously been lacking. For example, the motor-cyclist's crash helmet, presenting a chance of survival for those fool-hardy enough to drive these machines in British traffic, still remains an optional piece of equipment.

It might be expected that all possible measures for prevention of accidents be incorporated into the design of new roads, yet the M1 has only a few feet of soil separating the two fast opposing lanes, providing excellent conditions for disastrous accidents. This fault might be excused in a protoype of this kind, but the fact that the same defect has been repeated in more recent motorways is something more than just negligence.

Somewhere between the earnest recommendations for road safety and the screaming ambulance siren there is a silence which is allowing this sickening chain reaction to be perpetuated. This negativism suggests that the present road accident rate is accepted as inevitable or that it is still a small price to pay for the smooth running of the transport system.

There is still much to be learned about the causes of road accidents but if action is not taken on what is already known, then the prevention of these deaths will only be possible when the motor car becomes obsolete.

First Aid

A course of First Aid has recently been completed at Guy's. This course, which was the first of its kind to be included in the curriculum for pre-clinical students, was given by Lt.-Gen. Sir Alexander Drummond. This was a voluntary effort both by Sir Alexander and for the students who attended. Students who passed the examination at the end of the course will be qualified to conduct First Aid courses according to the Order of St. John to groups of volunteers amongst the public.

The course was entirely successful and thanks are due to Sir Alexander for the time he so generously spent in giving these lectures.

TOTAL MEDICAL CARE

J. A. D. ANDERSON

The phrase total medical care is high-sounding and has been used somewhat loosely in recent years. The interpretation of what is meant by the expression varies depending on the context in which it is used, and it is perhaps convenient to consider the level of care routinely offered by the three different branches of the health service in order to try and arrive at some conclusions.

Hospital Care

When a patient is admitted to hospital he is completely dependent on the medical services of one sort or another for all his needs. The chances are that prior to admission his spirit has been broken by a long session in the out-patient department, and by doubts and fears associated with the unknown.

Once the patient is in the ward it is not only aspects of care, generally accepted as being medical, which come under the control of those in authority but also such matters as food, drink, bed and accommodation. His clothes are removed and his contact with visitors from the world he knows is restricted in time and number by the regulations of the strange institution in which he finds himself.

The doctor is protected from his patients by the nursing staff and it is the most junior member of the medical team (and consequently the least experienced) who has closest contact with the patient. The hierarchial system by which the consultant in charge not only controls the earthly destiny of the patient but has a major say in the ultimate professional fates of the junior staff, enhances the feeling that some omnipotent being is in charge of the situation.

If the patient is on the surgical side of the hospital he may be unconscious during the active part of his treatment having previously given "carte blanche" to the surgeon. Under these circumstances the feeling of dependence and helplessness is even more pronounced than on the medical side where the patient normally retains consciousness.

Wherever he finds himself the patient may have difficulty in making direct contact with the doctors who discuss his case at length, order numerous investigations and then issue directions about treatment, while pronouncements about diagnosis and prognosis are couched in terms that may be difficult to understand. Mild protestations tend to be pushed aside on the grounds that the patient seldom knows what is best.

It is easy to criticise established practices and undue cynicism is as negative as excessive complacency. Furthermore, the image of the hospital specialist as a despot is a false one in many cases. Nevertheless, the aim of this paper is to consider total medical care, and if this is to be measured only in terms of the control of life and limb over a limited period then hospital treatment must come very close to being total in its scope—at least in the eyes of the patient.

This article is based on a lecture, originally given at Goldsmith College, in the series "Towards Better Medical Care."

In spite of all that has been said, admission to hospital and continued sojourn therein are entirely voluntary except in a small minority of cases. Even when compulsion is necessary to secure admission the physician in charge may discharge the patient more prematurely than some people think is desirable for the safety of the rest of the community.

Community Care

The medical practitioners who have the greatest scope for statutory coercion of patients are the Medical Officers of Health (M.O.H.). These doctors are concerned with the greatest good to the largest number of citizens, and inconvenience and restriction inflicted on individuals may be regarded as justifiable in order to bring this about.

The control exercised by the M.O.H. is not confined to his powers under statute. As an example of this one might consider the recent outbreak of typhoid in Aberdeen; the treatment of individual cases was the responsibility of the hospital doctors but the M.O.H. was responsible for the control of the epidemic including the pursuit of contacts. It is at such times that the M.O.H. makes use of his statutory powers to control the activities of many people; these direct actions affect mainly the local population, but the use of these powers and the phrasing of reports to press and radio have much more widespread results. Such reports can contribute significantly to the actions of friends and contacts outside the area which is directly affected. The term total medical care could be applied in the community sense to such a situation in that control is directed from the centre and this control is accepted by the community at least for the period of the epidemic. Criticism and adverse comment tend to come from both lay and medical sources after the event.

It is not only during an outbreak of infectious disease, however, that the M.O.H. is the medical exponent of statutory power. Laws have been enacted which cover all phases of life from the time of intra-uterine existence to the methods of ultimate disposal by burial or cremation. The air, drink and food which are consumed and the waste products exuded by both humans and industries are likewise the subject of legislation which can be invoked by the M.O.H. in order to coerce people into doing what he believes is best.

The basic function of the M.O.H. is to try and prevent disease at the community level and to give professional advice to local authorities which have to provide services for those with established disease and disability. This has resulted in some confusion of thought and a certain amount of rivalry between some medical officers of health and local general practitioners.

In order to understand these problems it is necessary to consider the place of the general practitioner in the community and to appreciate his role in total medical care.

Family Care

General practice is the third situation in which a doctor takes care of a patient. It is often postulated that the main differences between the general practitioner and those working either in hospital

or in the field of public health are that patients have freedom of access to the general practitioner and that he offers continuity of care beyond the immediate episode. This image is less true today than formerly because the number of group practices and duty rotas for general practitioners has increased. Also migration of families from one area to another, either seeking employment or because of rehousing, has led to families changing from one practitioner to another.

There are, however, many people who remain attached to the same practice all their lives and the term "family doctor" has been introduced as a synonym for general practitioner. The implication is that he concerns himself with the medical care of the family in contrast with the care of one particular disease in the case of the specialist, or the care of an entire community in the case of the M.O.H.

A further fallacy in this argument is that the family doctor is not necessarily responsible for all the members of a family nor even for all the members of a household. Clearly, figures will differ between practitioners and from one area to another, but in a working-class practice in Edinburgh[1] the number of households in which the related members were all registered with the same partnership was 1,028 out of 1,570 (64%). In the same practice one or more of the children under 15 had a different doctor from the mother in 47 (3%) of the households under care.

A similar study of the North Midlands faculty of the College of General Practitioners[2] presents the facts in a different way but indicates that families with split medical care are rarer in rural than in urban practices.

In spite of these reservations it seems fair to say that the family doctor looks after his patients in the setting of their own homes and that he cares for them both before and after they come under the close scrutiny of one or more specialists, he also has contact with patients in a more personal way than the M.O.H.

Dual responsibility

The general practitioner and the M.O.H. both have a responsibility for certain aspects of medical care. This arises from the fact that the M.O.H., or rather his staff, play an important part in the personal care of certain members of the community. This duplication sometimes leads to confusion.

The M.O.H. is responsible for maternity and child welfare services and the school medical officer, who is often the same person as the M.O.H., is responsible for the care of school children. These services are intended to prevent disease in the respective sections of the community, but their roles have changed during the past 15 years. Prior to the present National Health Service, the wives and dependents of those who were gainfully employed were not provided with statutory medical care in the way they are now, and therapeutic clinics were established by local health authorities to cope with these special groups. These were justified on the grounds that proper treatment of, say, an expectant mother, would prevent disease later on.

This broadening of the concept of preventive medicine to include therapeutic services led to a certain amount of rivalry between the

general practitioners and the M.O.H. Even now, nearly twenty years after the Act became law, the conflict has not been resolved completely. Many practitioners think they should be responsible for all personal services (including preventive ones) to their own patients, while most M.O.H.'s have reservations about this. In some cases the motive may be the rather negative one of self-preservation, and under these circumstances the issue is reduced to that of a demarcation dispute between two occupational groups; as such it is but poorly camouflaged behind a series of specious arguments about the role of the M.O.H. in community medicine. Others, who foresee a change in emphasis of the work of the M.O.H. from the field of preventive medicine applied to an individual to that applied to a community, nevertheless express doubts about the ability of general practitioners to practice preventive medicine. One of the opinions commonly voiced is that when preventive services are blended with therapeutic ones then the latter assume such a dominant role that the former are forgotten or at least receive perfunctory attention, especially in times of stress.

The concept of combining therapeutic and preventive services in the community has undoubtedly got advantages, two of which have a definite bearing on the problems of medical care in Britain today.

The first concerns the attitude of patients towards their own health. Few people consider the full implications of what they do or fail to do on a long term basis. It can be argued that this is a good thing, otherwise we should all be neurotic and the York Clinic would be flooded with a wave of anxious patients worried about the consequence of their own folly. On the other hand, an attitude of "laissez faire" is just as undesirable and can result in needless suffering and misery from sickness or injury which could have been prevented by some simple measure such as innoculation or health education.

It has been argued that ill patients are more likely to be attentive to ideas designed to improve or maintain health. Even if all the good resolutions made "under duress" on the sick bed are not put into practice when the patient has recovered, perhaps a few of the points may be accepted.

Exploitation of sickness to try and force the sufferer to do what is believed to be good for him in the future is tantamount to hitting a man when he is down and may not be in the best traditions of fair play. Furthermore, it would be very unfortunate if people were to postpone or avoid seeking therapeutic advice for fear of having to put up with a homily on clean living. Venereologists found that they had to respect this in order to get patients to attend early for treatment, and it is perhaps a lack of such appreciation by Clergy which has deflected so many of the spiritually and morally sick from the vestry to the consulting room.

The second advantage to be gained from combining preventive and therapeutic roles lies in the fact that information which is sent routinely to those with a therapeutic role may not be communicated to those whose function is solely preventive. An example of this is the policy of some hospitals to send information about babies and children only to the family doctor in spite of the fact that much of this infor-

mation could be very helpful to those with a statutory responsibility for infant welfare or for the health of school children.

This attitude towards sickness and the distribution of information is not confined to hospital doctors. Many patients have a pretty hazy idea of the exact place of the preventive services in the pattern of medical care. Those who are familiar with the tripartite structure of the health service may be able to grasp why a doctor at a child welfare clinic can give advice on certain aspects of medical care and can dispense cod liver oil, but is barred from writing a prescription for ointment to treat infantile eczema. To many ordinary citizens, however, a doctor is a doctor and if he cannot treat something then he cannot be a "proper doctor".

If the functions were combined then difficulties such as these would disappear. Furthermore, it is possibly better for the therapeutic role to take precedence in contacts made with those fulfilling a combined function of treatment and prevention than for the preventive role to be supreme when contact is either non existent or difficult to achieve.

The same arguments apply to the relative roles of the district nurse and health visitor. Here again both doctors and patients are often confused and family doctors, who are supposed to be the direct link between patient and health service, may have only a hazy idea of the duties of health visitors.

In a recent enquiry[3] conducted with the help of a random sample of 52 general practitioners it was found that whereas 49 (94.2%) had a full knowledge of the role of the district nurse, only 30 (57.7%) had similar knowledge about health visitors ($p<0.001$). Furthermore 45 (86.5%) of the practitioners interviewed had had contact with a district nurse during the previous month, while only 11 (21.2% had had contact with a health visitor during the same period ($p<0.001$). In the same enquiry it was found that 23 (44.2%) of the doctors interviewed had never had any contact with a health visitor at any time. A separate enquiry at present being conducted by the Queen's Institute of District Nurses may have some interesting comments to make on the adequacy of information given by general practitioners to the district nurses dealing with their cases, but at least some contact is being made, whereas relationships between practitioners and health visitors are often very poor and in many areas there is hostility between them.

Similar antagonism exists between family doctors and hospitals and representatives of each of the three branches of the health service are prepared to draw schematic diagrams representing total medical care with themselves at the centre of a complex series of boxes and arrows. In an ideal world the family doctor could and should be the conductor of the orchestra; this would depend on general practitioners having the time, tools and training to perform the task. It would mean also that those working in the other branches of the health service would have to have a clear idea of their own roles in the pattern of medical care. Coincident with this, hospital doctors and M.O.H. would have to be convinced that the general practitioner was willing and able to do the job properly. Some of the doubts and

uncertainties of all those involved are reflected in the present crisis in general practice, and these are summarised briefly here:—

1. Therapeutic Advances

The replacement of potions and mixtures by powerful medicaments with specific actions has reduced the importance of the personality of a doctor in the healing process of many major diseases. It is penicillin and not the beloved physician who cures pneumonia, and the general practitioner often gets little credit for his contribution. Furthermore, the stock equipment used by the family doctors can now be bought in plastic kits as toys equivalent to those of a bus conductor or a postman; in hospital, however, therapeutic advances have been associated with elaborate equipment some of which makes even the imagination of H. G. Wells appear prosaic.

2. Knowledge of patients

Victorian prudery dies hard and some still consider it indecent to discuss any part of the anatomy between the clavicles and the tibial tuberosities. This, however, is no longer general; glossy magazines, Sunday newspapers and television have informed wide audiences of what they believe to be the truth about medicine. The admission of scientists without medical qualifications into the fortresses of medical research and treatment has meant that more and more people are coming to realise that the practice of medicine is merely one skilled occupation among many. This particularly applies to general practice, whereas the hospital doctor can continue to hide behind the mystique of gadgets and equipment; their usefulness may be questionable but none the less seem to impress patients in the same way as painting with betel juice and feathers in the hair, used by witch doctors, impress their gullible clientele.

3. Interesting work

Investigation and treatment carried out in hospital appears more interesting to the average doctor than does the routine of general practice. This is so in spite of the fact that the work of many specialists, particularly for instance E.N.T. surgeons, may be far more repetitive than the work of a family doctor.

4. Pattern of Morbidity

The clearance from the scene of so much gross organic disease has led the public to base complaints to an increasing extent on social and psychological grounds. These are often insoluble; in spite of the fact that his advice is sought, patients seldom accept that the doctor is better informed about social pathology than they are themselves. Furthermore, a general practitioner has no escape from these problems; by contrast his hospital colleagues dismiss such cases as "functional" and devote their time to practising "proper medicine."

5. Professional status

The clear cut differentiation between the professions (traditionally such as medicine, law and the church) and those formerly of less standing has become much less sharply defined. Many other occupations have achieved the status of "professions." Furthermore, many of the

workers in these new professions earn as much or even more than some doctors. This means that doctors cannot cloak themselves in mantles of superiority either on grounds of social class nor of financial earning, and the profession which stemmed from the humble origins of barbers and grocers finds this tendency to revert towards the mean somewhat irksome. This reversion has been more dramatic in the case of general practitioners than hospital doctors.

6. Career structure

The career structure in hospitals and indeed of the doctors working for local authorities induces an urge to advance, and maximum salary scales may not be reached until the age of 45 or more. In general practice the initial salary usually puts the practitioner above his contemporaries working in other fields, but the ceiling is reached rapidly and little remains for which to strive. All general practitioners are apparently equal, while in other branches of medicine there appears to be more chance for the able and hard-working to make progress (and who at the age of 30 years does not think naïvely that he has the wit, endurance and application to reach the top?).

7. Team leadership

The cohorts of ancillary workers and research assistants which surround the successful specialist are regarded with a certain amount of envy by the family doctor. The M.O.H. also is seen to be the effective director of a team of doctors and nurses, while the general practitioner for his part has to struggle on with his part-time nurse receptionist, 40% of whose salary is an expense against income tax, while the remainder has to be deducted from personal earnings.

8. Isolation

Hospital doctors and others work in teams and derive mutual support from this. By contrast many family doctors are either single-handed (approximately a quarter of all those giving unrestricted services[4] or work in partnerships which are based largely on financial agreements where there is little mingling of patients apart from holiday rotas or emergencies. However self-confident these practitioners may appear, many must have sneaking doubts about the adequacy of their knowledge after they have been away from their protective teaching hospitals for a few years.

9. Education

Perhaps the most important contributory factor of all is the fact that many medical schools continue to base all their clinical teaching on hospital cases. The young doctor is trained to be a hospital specialist, and until recently few students were allowed to venture outside the confines of their teaching hospital, and this has resulted in three major shortcomings: —

(a) *clinical material.* Less than 3% of consultations with general practitioners result in a referral to hospital [1]. The material reaching the hospital is thus highly selected, being dependent on the need either for detailed investigation or for specialised care and treatment. Many of the cases selected in this way provide useful clinical material for instruction, but this remains a fortuitous occurrence, and in general the referral of a patient to hospital is not based on any consideration

of what might or might not be good teaching material. Cases of lobar pneumonia, otitis media, pyelitis, rheumatic fever and a host of other potentially dangerous diseases are being treated at home without going near hospitals of any kind.

It is true that in countries where no National Health Service exists, economic considerations may force the poverty stricken to attend hospitals for charitable treatment of all their ailments. In Britain, however, community services have become more developed and specific therapeutic agents have become more freely available. This means that many of the cases which are being referred to hospital tend to be somewhat bizarre.

(b) *Episodes of illness.* Diseases in hospital have a beginning (on admission) and an end (on discharge or death); hospital episodes are therefore neat and tidy. This is an over simplification because a proper history will reveal that patients may be ill for quite long periods before they reach the hospital. Unfortunately, however, opportunities of seeing important prodromal symptoms and signs may not be available in the hospital setting; furthermore, there may be little chance of assessing which factors influence general practitioners to refer patients for second opinions. In addition, students have little chance of appreciating the upset and commotion which precedes a visit to hospital, and this in itself encourages the view that patients are merely soulless bundles of disease.

At the end of the hospital episode patients disappear through the door and students (in common with many of the staff) have only a hazy and theoretical concept of what happens next; a case of mitral stenosis is replaced by one of disseminated lupus and life (for the hospital) goes on as before.

(c) *Specialist teachers.* The separation of teaching hospitals from others in England and Wales has had unfortunate repercussions. There is a tacit assumption that the quality of medical care is higher in the former than the latter, and it is reasonable to assume that this idea is unlikely to be dispelled by the clinical teachers who constitute the staff of the teaching hospitals. There is a danger therefore that the cult of specialisation will be perpetuated.

10. National Health Service

Most of the factors which have been described are the result of therapeutic and sociological advances and are not peculiar to the existence of socialised medicine. However, the terms of the National Health Service Act have aggravated matters in certain ways.

(a) The division of the service so that family doctors are placed in a group by themselves has increased the feeling of isolation and has accentuated the differences which already existed between the different methods of practising medicine.

(b) The payment of doctors by the State enables doctors and others to calculate exactly what they are earning. The exception to this is the system of merit awards which operates among consultants: under this system those who have awards are content to say nothing, while those who do not are unwilling to let it be known that they have

not been considered worthy. Payment from public funds has another important side effect, namely, the scrutiny of expenditure by paid and unpaid watch dogs. There is little doubt that any criticisms are more likely to affect the morale and reputation of the isolated family doctor than those who are protected by the amorphous mass of hospital or local authority where the blame can be passed down until it is dissipated.

(c) A mood of political controversy was associated with the introduction of the health service. Many older doctors still correlate the start of the health service with deterioration in their status regardless of whether or not these two events might be coincidental occurrences.

Conclusion

It is easier to enumerate difficulties than to suggest remedies. At the same time remedies commonly come only after a clear understanding of the nature of the problem has been achieved, and as far as the present generation of doctors is concerned, perhaps the best that can be hoped for is that rationalism rather than emotionalism prevails.

Current policy must ensure that future practitioners in any branch of the health service understand the problems of total medical care and indications are that some medical schools are becoming aware of the dangers and are endeavouring to change the role and image of the teaching hospitals. The latter are to function as district hospitals for their respective areas, and ideally this should be coupled with sending students to district hospitals for part of their training. A few schools are planning to expose students to medical care outside the hospitals by organising compulsory attachments to general practitioners, and by supplementing such attachment schemes by a spell with a G.P. teaching unit. It is to be hoped that attachments of this kind will include an introduction to the field of work of the local health authority and not merely confine themselves to demonstrating the therapeutic aspects of general practice.

Plans for such a scheme are under way at Guy's, and the project, which has already been described in this Journal [5], includes plans for a comprehensive medical service based on co-operation between the different health and welfare services. It would be naive to think that this will achieve total medical care, but at least it is encouraging to think that it is being attempted.

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A Visit to Pitcairn Island
by Michael D. Steyn

It is probable that Guy's men, whether they be medical or dental, have penetrated most corners of the globe, but it would be interesting to know if anyone has had the experience of landing on Pitcairn Island, that romantic island in the South Pacific of Bounty fame.

Having joined Shaw, Savill and Albion Co. Ltd., in May, 1964, as ship's surgeon on the s.s. *Athenic*, a first-class passenger-cargo vessel running to New Zealand via Panama, I first came into contact with the Pitcairn Islanders, and later was to have the experience of landing on their island.

Pitcairn is a fascinating island and, before recounting my visit, a short history may be of interest.

As you sail towards Pitcairn you approach one of the world's most remote inhabited islands lying half-way between New Zealand and the Americas. It is a small volcanic island 2,950 miles E.N.E. of Auckland and over 3,500 miles from Panama in the N.E., being about 500 miles N. of the great circle route between these two ports. It is of irregular shape and remarkably small, being only some two miles long by a mile wide, and its area is 1.75 sq. miles. Flat or flattish land forms only eight per cent of the total surface, steeply sloping land and cliffs 61 per cent. The highest point is 1,100 feet, and from the bridge of *Athenic* on a clear day it can be seen 45 miles away.

The first settlers of the island are not known, but many relics of Polynesian civilisation (they include stone gods, carvings of animals and men in the cliff faces, and burial sites) have been found.

The first sight by a European was in July, 1767, by H.M.S. *Swallow*, and it was named after a young midshipman Pitcairn on that ship.

The tale of the mutiny on His Majesty's armed ship *Bounty*, which led to the founding of the Pitcairn community is well known. All that need be told here is that on 28th April, 1789, when the *Bounty* was in the Tonga group on her way home from Tahiti with a cargo of bread-fruit trees for planting in the West Indies, the master's mate, Fletcher Christian, and others of the crew, mutinied. Casting adrift the Commander, Lt. William Bligh, and 18 loyal officers in the ship's boat, the mutineers sailed the *Bounty* back to Tahiti.

Deterioration of relations with the Tahitians led Fletcher Christian, remembering the account of H.M.S. *Swallow*, and the other mutineers, with six Tahitian men and 12 Tahitian women and an infant girl, to search for Pitcairn island, where they landed in 1790.

The first reliable estimate of the population in 1808 was 35, and by 1856, the year of the migration to Norfolk island, it had increased to 194. By 1864, 43 people had returned to Pitcairn, and in 1937 the population reached its peak of 233. Since then it has declined, and at present is about 85.

Houses are often modern inside; they are made of wood, and many have the luxuries we expect at home, including electric light, telephones, refrigerators, washing-machines, radios, gramophones, and

pianos. For all these items, which are something special to them, though necessities to us, the islanders rely completely on the friendship of passing ships' captains and the shipping companies.

There are about 70 houses in Adamstown where the islanders live; probably about half only of which are occupied. Adamstown is on the N.E. coast of the island, and its many small houses, hidden in the luxuriant tropical vegetation, look down on to the only safe landing place in Bounty Bay. Here, in 1790, the *Bounty* was run ashore and burnt, lest the mutineers be detected.

The only relics now of the *Bounty* can be seen on the island. The anchor, recovered in 1957, lies outside the courthouse; the ship's bell, still in use for calling the islanders to meet, is close by; and the Bounty Bible, on permanent loan from the Connecticut Historical Society, and the islands greatest treasure, is inside the church.

Pitcairn's economy falls into two distinct parts. The private economy depends almost exclusively on subsistence, farming, and trading; the public, on income from the sale of stamps and on interest from investments. Trading is done on visiting ships, and is confined to fruit and souvenirs. The latter, e.g. turtles, flying fish, vases, walking sticks, baskets, fans, and hats are made by all the islanders—Miro wood, from neighbouring Henderson Island 100 miles to the N.E., being used for the carving. This is their only source of personal money.

Island officers are elected amongst themselves, namely Chief Magistrate and committee, postmaster and policeman, but for education, religion, and medical welfare, the Pitcairners rely on outsiders who serve a two-year period. The education officer is provided by the New Zealand Department of Education. There has never been a resident doctor on Pitcairn Island nor, so far as can be traced, was there a nurse until an appointment was made in 1934 in co-operation with the Australasian Union Conference of the Seventh Day Adventist Church. It is now the usual practice for the wife of the resident Pastor to be a trained nurse. All the islanders are Seventh Day Adventists and have been since 1887. Smoking, drinking alcohol, and the eating of meat is taboo.

Their diet, because of lack of meat, is high in carbohydrate, and they are almost all inclined to be overweight. They eat large quantities of fruit, e.g. oranges, grapefruit, pineapples, bananas, watermelon, avocado pears, and passion fruit.

They have their own peculiar game of cricket which is a free for all, each side batting seven or eight times, and anything up to 800 runs being scored in the one day. They speak good English, but in addition have their own quaint Old English dialect which gives rise to some delightful place names on the island such as "Where Dick Fell", "John catch a cow", "Where Tom Off", and "Broke im Hip". They also have the largest and widest feet I have ever seen, owing to their dislike of shoes.

Shaw, Savill and Albion Co. Ltd. are the only shipping company whose vessels make regular calls, since the vessels of the New Zealand Shipping Co. were withdrawn in 1962. Other vessels break their trans-Pacific voyage there, but irregularly and without warning. The frequency of visits has fallen from 65 in 1956 to 39 in 1962. At present

the "Gothic" class vessels of Shaw Savill (four including *Athenic*) pay between them 20 visits a year at regular intervals. As I write, *Athenic* and one other have been withdrawn from the route, making only 10 visits yearly, and shortly the remaining two ships will be taken off too. If the Pitcairn community is to survive, then it will be necessary for another shipping company to send their ships by this route.

Medically, the Pitcairners rely on the willingly given assistance of surgeons from passing ships, which call at the island on an average of one every ten days, or which can be summoned by radio if they are in the vicinity. It must be remembered, however, that there might be an interval of weeks between ships while at other times three may call in a week.

As ship's doctor, one is always faced with a queue of islanders when one calls, who provide gifts in exchange for advice. Life can be quite a problem when one stops to think that the nearest Out-patients is about 3,000 miles away, and I have had to refer cataracts, a prolapsed intervertebral disc, and fractures to Auckland.

It was as ship's surgeon on the *Athenic* that I had the opportunity to land on the island, an experience which very few are ever likely to have. Doctors of passing vessels are the only members of the crew able to claim this unique experience, as for anyone to land on the island special permission has to be granted by the island administration in Fiji. So many people see the island each year; a rough estimate would be 500 passengers and 1,000 crew; it understandably attracts a lot of interest, and on the occasion of a landing one becomes the centre of much attention.

Of all these people who pass, visitors number between five and 10 a year, mainly on government work concerned with administration or agriculture, but now and again an author, surveyor, or anthropologist land to study the island and its people. A doctor sent from Fiji lands every two years to vaccinate the islanders and inoculate them against typhoid fever. They have all been immunised against poliomyelitis.

As ship's doctor, approaching the island, there is always the chance that one's services might be called upon, and after passing the island only once it occurred to me what an experience it would be to land there; it seemed so near yet so far away. Little did I realise I was soon to have the opportunity.

Returning home on my second voyage in December, 1964, the call came. It was December 9th, and we were 12 hours from the island; a young mother had given birth at mid-day that day and had suffered an extensive second degree tear, would the surgeon please come ashore to repair it? (This, in fact, was the first birth on the island for over three years; most mothers go to New Zealand to have their children.) Permission was granted by the Master, and my adventure was to begin.

An obstetric bag was prepared (I can imagine the instruments had never been used—they are hardly necessary when one considers the average age of the passengers, which is usually well over 60) and plans made should there be any question of bringing the patient aboard for further treatment, and I retired to bed, minus the usual night caps, ready for an early start and excited at the prospects of the next day.

We were off Pitcairn by 7.30 a.m., and soon Mr. Brian Hills, the Chief Officer, and myself were descending the seemingly endless (to me) pilot ladder to the long boats ready for our trip of a mile-and-a-half to the shore.

We soon discovered that the patient's husband was in charge of the long boat—he was the islands engineer—and he was quite resigned to the fact, that his wife might end up in hospital in Panama.

Our camera was working overtime as we approached the island, and we landed in Bounty Bay feeling not like mutineers but nevertheless as if we were treading on ground where few people had trodden before, and in view of the islands future, where few would tread again. We shot in on a roller and alongside the tiny quay to be met by Pastor Ferris and his wife, the nurse. We were then faced with a very stiff climb of about a quarter-of-a-mile to Adamstown to see our patient in the clinic there.

All around us was the typical luxuriant tropical vegetation in which the island abounds, pineapples growing (I learnt those didn't grow on trees), bananas ripening, hibiscus flowering, and avocado pears, the envy of any West End restaurateur at 7s. 6d. a time, lying rotting on the ground.

In Adamstown we stimulated the curiosity of hordes of small children, many typically English in appearance but in addition a number with Polynesian blood in them. The patient was in good spirits, and fortunately the tear was not as bad as anticipated, and it was soon repaired. The baby was just the right side of prematurity and full of vigour.

We saw the Bounty Bible and the Bounty anchor, and met many of the islanders and went into their homes—it was a great occasion for them as well as us—and Mr. Hills had a good look round the island, taking all photographs in duplicate. We signed the visitor's book before descending to the landing place, and heading to the *Athenic* and an impatient Captain, with many gifts which had been pressed on us.

The island clinic was large, airy, and spotlessly clean, with a full range of emergency equipment and drugs—it was most impressive. Emergencies, as such, never occur, which is no doubt a great relief to the nurse, who is completely on her own. In spite of her excellent work on the island, one can't help thinking there are better places to have have acute retention or appendicitis when one's nearest hospital is in Auckland, just under 3,000 miles away.

Edgar Allen Lloyd, L.D.S.

Edgar Lloyd was a man who earned great respect during the many years that he was at Guy's. Soon after the outbreak of the 1914-18 war he went to France with the Welsh Horse. Like Captain Stuart Surridge, M.C., R.F.C., and the group of Guy's dental students who behaved with such gallantry when they were serving with the Artist Rifles during the battle of the Somme, Lloyd looked for a more active life and obtained a commission in the Royal Flying Corps, where he served in the 66th Squadron under Group Captain Ball, V.C. Returning to Guy's, he qualified L.D.S. in 1923 and became a Dental House Surgeon, and afterwards was for many years a Demonstrator on the Staff of the Dental School. Lloyd was a skilful dentist also, as was to be expected from his war service; he was a man of character, quiet, forceful, and exercising great influence, both on the students and on his colleagues on the staff.

CORRESPONDENCE

Peter in A

SIR,—Allow me to congratulate you on those arresting headlines in your last issue on page 356, " Eye disorders, Peter in A. Handicapped Gardiner children." I note carefully that these children are not just little simple-minded gardeners (with silver bells and cockle shells and pretty maids all in a row), but members of a family called Gardiner, of which Peter naturally is one. They are in A. What is A? A stands for "asylum" I believe; but as really nice people do not use that word now, you have had it cut short out of decency.

Peter is tormented by the apparition of an eye. A parallel can be found in "The Horror of Studley Grange" recounted in *The Strand Magazine* in its early days. Oh that awful tap, tap, tap, in the dark! Then the immanence of the gleaming, preternatural eye! And last the dread finger that beckoned to the grave! A distracted woman dying of consumption contrived it by means of a shielded light and a laryngosopic mirror, and no doubt an inmate of A has been "disordering" Peter by similar means.

But a friend believes, sir, that what you really wrote was this: " Eye disorders in handicapped children. Peter A. Gardiner", and that somehow the words became jumbled. I feel sure you would have written, " Disorders of the eye", and I dismiss such a paltry notion as a jumble, unworthy of the *Gazette*.

Yours, etc.,

H. ST. H. VERTUE.

Larch Tree Lodge,
37, Tower Road,
Orpington, Kent.

Matron's Ball

SIR,—Seven hundred people gathered at the Dorchester Ballroom on the 9th June to make Guy's history. This was the first Matron's Ball to be held in a public Ballroom with the exception of last year's Ball, held at the Cloth Makers' Hall, emphasising the ties between Guy's and this excellent Guild.

Seven hundred people is a crowd in any hall, and the Dorchester, despite its size, was no exception. Nevertheless, in spite of the fact that numerous nylon stockings were ruined and eyes blacked in the fray, an excellent evening was had by all.

A first-class dinner was tastefully served, leaving an adequate time (certainly for the squares amongst us) for dancing to the music of Tommy Kinsman.

It is hoped that a function of this sort is here to stay, but may I make a plea for larger premises, also catering for the unfortunates, who were unable to obtain tickets this year.

Yours, etc.,

B. A. ROSS.

61, Trinity Church Square,
London, S.E.1.

NOTICE

WANTED—by Guy's Hospital Outpatients' Department, in therapeutic setting, a doll's house with 4 bedrooms, 3 reception rooms, kitchen, bathroom and toilet, garage optional, or similar property. Anyone wishing to donate such a house with freehold, please contact the Guild of ex-Patients Guy's Hospital.

PAUL

This is by way of an obituary—on a man of Guy's. Not that he was ever a member of the staff. But over the years he became very much a part of the place—in his capacity as a patient. And during that time he gave to the hospital the most devoted allegiance.

He first saw the light of day in Vienna, nearly sixty-six years ago. Upon leaving school he entered the hotel business which, in a cosmopolitan rôle, he was to serve for the rest of his life—apart from a spell in the Austrian army during the latter half of the First World War.

In 1920 he moved to England and subsequently adopted British citizenship. He became a well-known figure in the cocktail bars of some of the most fashionable hotels, from Shepherds in Cairo to the Ritz and Grosvenor House in London. What is more, as an emissary and plenipotentiary of the Bartenders' Guild, he was diplomat extraordinary known throughout the world. Mention of his name, or presentation of his card, when ordering a drink in Rome, Oslo, Frankfurt or Sydney was, as a number of Guy's men will testify, a guarantee of immediate welcome and the most royal of receptions.

Medically and surgically he was no less remarkable. In 1937, for a reason that is not clear, he underwent an abdominal operation in Belgium. This left him with an enormous ventral hernia which, for many years afterwards, was controlled far from adequately by an abdominal support.

Four years later he volunteered for service with the British Forces —and was discovered then to be a severe diabetic. For this he was ordered insulin injections and dietary restraint—a regime that was not exactly calculated to appeal to a man of his calling.

Then, in 1951, at the age of 52, he suffered his first, and quite severe, myocardial infarction. For this he came to Guy's and remained in the ward for six weeks under the care of Dr. Douthwaite. Though he returned thereafter to his previous occupation he never, from that time, really got beyond reach of the place. A year later, attending for a routine check, he mentioned to Dr. Finnegan something about bowel irregularity. Suspicion was aroused, investigations were called for and, as a result, Mr. Glover carried out a right hemicolectomy. The specimen removed was not only beset with polypi but bore no less than five obviously carcinomatous lesions. Secondary deposits were, fortunately, lacking and recovery was complete and rapid.

In 1956 a second myocardial infarction took place. This time he was an in-patient under Dr. Hampson. Three years were to elapse before the next bout of symptoms, those unmistakably of sub-acute small gut obstruction. A neoplastic recurrence was not unreasonably feared but, at operation by Mr. Wass, only numerous adhesions were found. These were divided with some difficulty and the abdomen was closed, but only after some struggle with the most voluminous intestine that seemed to refuse stubbornly any efforts to restore it

beneath the otherwise capacious abdominal hernia. Any reduction of this was at that stage out of the question. Yet, two weeks later, the patient was out and about again—still diabetic, of course.

At the end of 1962 he was complaining of pains in the feet and legs. Admitted under Professor Butterfield, peripheral arterial insufficiency was diagnosed, with a block of the left popliteal artery. Treatment was started for this condition when, among four specimens of faeces examined, three were found to be positive for occult blood. A barium enema demonstrated two obstructive masses in the remaining colon. Mr. Glover proceeded now to a left hemicolectomy, removing two more carcinomata in the process and forming an end-to-end anastomosis of the illeum and pelvic colon. Once more recovery was rapid. The patient resumed work at Grosvenor House—still with diabetes, a ventral hernia and, more worrying still, persistent and uncontrollable flatulence which, as he said, made it somewhat difficult for him among his clientele!

A professional trip to Germany was then undertaken. There, with shattering suddenness, small bowel obstruction again overtook him. He was flown back to Guy's, admitted as an emergency and Mr. Maynard operated. Once more, numerous adhesions were divided and, what was more, the hernia was repaired. Rehabilitation was so complete that, before long, a hotelier's conference in the region of Milan became the next venue. Whether or not he over-indulged himself there among the gargantuan revels as some suspected, or whether—as he insisted—it was due to the high altitude, he was shaken by praecordial pain and vomiting. The Italian medicos diagnosed a coronary, a return flight to England was hastily improvised and a bed was found for him in the medical wards. Professor Butterfield again took charge. An antero-lateral infarct was confirmed and pulmonary oedema with, possibly, aspiration pneumonia was also noted. This time his improvement was more delayed and the peripheral vascular deficiency persisted, with such intensity that in May, 1963, Mr. Ellis had no alternative but to resort to a left, below-knee-amputation. Then, just as everyone thought he was weathering this satisfactorily, a sinister-looking proliferating lesion appeared superficially on the right thigh. After excision Professor Nevasquez fortunately pronounced this a sebaceous adenoma.

Now all of this might have seemed quite enough for one man. But no, early in 1965—by which time he had proved himself thoroughly peripatetic upon his limb prosthesis—he was brought to an acute halt one day at a bar-tender's meeting by urinary obstruction. This time it was Mr. Kilpatrick's turn and he carried out a prostatectomy. Yet again, gratifying recovery ensued.

From then on, Paul attended the Department of Medicine outpatient clinic where, under Dr. Boyne, he continued to make steady progress and resumed his welcome patronage of various of the more select restaurants in London. Then, one morning, a couple of weeks ago, he left his flat unaided, joined some friends at a breakfast reception, returned home afterwards and—failed to keep another appointment for lunch. He had fallen dead in the lavatory.

Epilogue. To put it mildly, this man had suffered more than his share of life's afflictions. Yet he bore all his reverses stoically, lost no opportunity in taking his place in that social life which was the very essence of his existence and was overwhelming to the point of embarrassment in his gratitude to Guy's. No other hospital, in his eyes, could measure up to it. At the same time he was a lesson to us all, prognostically. By recognised standards he should have succumbed long ago. Yet he almost made the psalmist's span. The world will be a much duller place without him. And no one will miss him more than the ever-increasing membership of that informal club of which he was automatically the president—that group of Guy's men that he gathered around him and sought to repay for the help he considered they had given him professionally, medically or surgically. They were tremendous evenings when he played the part of host—now an unforgettable memory.

REVIEWS

THE CRANIAL NERVES.

Anatomy and Anatomico-Clinical Correlations. Brodal. 2nd Edn. Blackwell Scientific Publications, Oxford.

This pocket book sets out the cranial nerves in reverse order, describing for each its anatomy, its function and the clinical applications of these. Presumably it has been written for the student who has a special interest in neurology and the postgraduate beginning his neurological studies. Professor Brodal is an anatomist, and it is when describing the anatomy that he is most lucid and informative. The clinical aspects, however, contain a sufficient number of errors to be misleading. For example, he states that the superior oblique muscle acts so as to depress and abduct the eye (P 103), while clinical evidence indicates that it functions as the main depressor of the adducted eye; oculomotor nerve paralysis does not leave the superior rectus muscle unaffected (P 104) (this must be a proof-reading error); constriction of the pupils is most strongly produced by convergence rather than by accommodation, and this does not require intact vision (P 116).

These are some of the statements in this book which detract from its value. It cannot therefore be wholeheartedly recommended.

SIMON NURICK.

DYNAMIC PATHOLOGY,

by M. M. Black and B. M. Wagner. The C.V. Mosby Co., 1st Edition, 296 pages. *Price* £3.

This American book is not intended to teach pathology and in fact, demands some knowledge on the part of the reader. For this reason it is not the book for the student who considers pathology simply as a hurdle to qualifying. The first part deals with the homeostatic mechanisms of the body starting with a description of a "typical" cell. It then goes on to consider the part played by various systems in maintaining the body in health, describing their responses to various pathological insults.

The second part of the book deals with neoplasia, ionizing radiation, deficiency and infectious diseases as a challenge to the homeostatic mechanism. The last chapter on ageing is dealt with in a slightly philosophical air, putting forward the concept that without death there is no life. It is perhaps enriched by a twenty-four line quote from " As You Like It." The book is attractively set out, the contents of a chapter being given as a list of headings at the beginning of the chapter. The only criticism of the excellent photomicrographs is their paucity, although the authors do present their reasons for this in the preface. For those whose interest in pathology goes further than exams., the book is certainly well worth reading.

P. GARCIA-WEBB-SHARP.

ANAEROBIC BACTERIOLOGY IN CLINICAL MEDICINE.

by Trevor Willis. Butterworth's. Pp. 234. *Price* 47/6.

This book provides a critical analysis of apparatus and methods of culture, which may be used in the identification of anaerobic bacteria. It gives a concise, but detailed, account of the properties of the pathogenic anaerobes, and also an excellent review of the diseases caused by these bacteria. For the undergraduate, the latter section will be both instructive and interesting, while the former more technical section would be useful for reference purposes. For the bacteriologist and technical staff it will be an excellent practical guide. In its compilation the author has reviewed an extensive field of literature, and therefore it will be of use to those who wish to make deeper studies into the field. Despite the comprehensive nature of this work, it yet remains brief, a quality much to be appreciated when one looks at some other bacteriological tomes. It is definitely to be recommended for laboratory and library shelves.

GERALDINE MCCARTHY.

ELECTROCARDIOGRAMS: A SYSTEMATIC METHOD OF READING THEM.

by M. L. Armstrong. Wright & Sons, Ltd. Pp. 64. *Price* 17/6.

This short book on electrocardiograms presents a systematic approach which provides a discipline in reading them. The author sets out a logical sequence of observations whch should lead with some certainty towards a correct diagnosis. Although it is unlikely that its method would be pursued by the student as dogmatically as it is presented, it is clearly written and provides a reasonable introduction for the undergraduate.

Some of the reproductions are of poor quality and little attention is drawn to acceptable variations in the normal E.C.G. Theory has been completely omitted.

This is a straightforward uncluttered approach to the electrocardiogram which provides a logical method, and as such it is a sound introduction.

A. E. RAYNES.

MEDICAL MICROBIOLOGY.

Edited by R. Cruickshank. Published E. & S. Livingstone, Ltd. 11th edition. 1965.

This book aims to be "A Guide to the laboratory Diagnosis and Control of Infection." This it does pretty thoroughly in 1,000 or so pages of compact, to the point writing.

It covers the field of parasitic and commensal organisms which live in or on man. The book classifies them in a clear manner, something that many bacteriologists and virologists seem to have difficulty in doing. Apart from the organisms and the diseases they cause, there is a section on applied microbiology and the methods of micro-organism study.

I think one of the biggest drawbacks to this book is that it contains no coloured pictures, something that is vital if the reader is not familiar with the appearance of organisms. There are a few black and white photographs and many excellent drawings, none of which are adequate substitute. Some sections

of the book are set out almost in note form which is useful for reference or solid learning if you are a Professor, but no good for interest reading.

As a whole, Medical Microbiology is too large a book for the medical student, although the keener students may like it as a reference book. It is too comprehensive for Nurses.

I do recommend it as a Christmas gift to any bacteriology lecturers you may know. P. HALL.

REVIEW OF MEDICAL MICROBIOLOGY.

6th edition. By Ernest Jawetz, Ph.D., and Edward A. Adelberg, Ph.D. Oxford: Blackwell. Los Altos, California: Lange. 1964. Pp. 453; illustrated, 45s.

Nowadays, when even pharmaceutical advertisers use electron micrographs, it is becoming increasingly important to be familiar with the microbiological aspects of disease. This book aims at providing " a brief, accurate and up-to-date presentation of those aspects of medical microbiology of particular significance in the fields of clinical infections and chemotherapy." The chief attraction is that within the 450-odd pages of this conveniently sized book, the topics of bacteriology (including a chapter on microbial genetics), virology, immunology, mycology and parasitology are covered in considerable detail. The text is lucid and readable and the diagrams and illustrations are clear and valuable. The more familiar one becomes with this book the more one is impressed by its quality and value for money. CHRISTOPHER DAVIES.

BAILEY'S TEXTBOOK OF HISTOLOGY.

Copenhaver. Bailliere, Tindall and Cox. 15th Edn. 665 Pp. *Price* 108/-.

The text of this fifteenth edition is neatly divided into 22 chapters, and the good index provided enabled me to get to know the book quickly. The last edition published in 1958 necessitated revision and re-writing of chapters in order to replace out-of-date interpretations with current information. The author has achieved this aim. He scores on other textbooks of histology for medical students on the reproduction of colour plates and excellent electron micrographs. These are well explained by the simple and easily comprehensible text. The book is written for students rather than professors, and in this theme commences with discussion on the living cell, Morphogenesis, special tissues then leads on to specific systems. The text is comprehensive and in parts laboriously detailed, yet emphasises the intimate relation of physiology and pathology to microscopic and macrascopic anatomy. Unfortunately, the majority of references come from the wrong side of the Atlantic.

I would recommend this textbook from Columbia University to 2nd M.B. students, but its cost is prohibitive at £5 8s. Also the text in my opinion is too long for the average pre-clinical student. M. A. Q. JAMIL.

CORRELATIVE NEUROANATOMY AND FUNCTIONAL NEUROLOGY.

J. S. Chusid, M.D. and J. J. McDonald, M.D. Blackwell Scientific Publications, Oxford. 12th Edn.

This book is one of a well-known series published in soft covers with a planned life in the region of two years; there have been nine editions since the war. It is not intended to be basic reading for students learning neuroanatomy, neurophysiology or clinical neurology; but rather to be a supplement to standard texts, certainly it presupposes some knowledge of neurology. In a book of only 400 pages, the field it attempts to cover is perhaps too large, and this is accentuated by the prominence given to some items out of all proportion to their merit, for instance, nearly a page is devoted to illustrating five different eponymous methods of eliciting the plantar response. There are a few minor errors in some diagrams which could be misleading (pages 52 and 158). However, this is a useful compilation of neurological data which is very extensively illustrated with excellent drawings and diagrams, and can therefore be recommended to the more discriminating reader as a ready reference to a wide range of basic neurology. M. D. O'BRIEN.

SPORT

CRICKET

At a time when the season is almost finished (the tour, which will be fully reported later, is now taking place), it is convenient to review the success of the side. In terms of facts and figures, of 27 games played, Guy's won 8, lost 11 and drew 8. These are reasonable figures, but not up to the standard of the past three or four years. However, when one considers that this was a young and relatively inexperienced side, they appear more successful.

Hambleton, who last year scored over a thousand runs, could play only once, and of last year's highly successful opening attack, Walter had left, and Knott was able to play infrequently. This left large gaps to fill. R. Beecham opened the bowling throughout the season, while J. Cutler, who has been playing for Westcliff for three years, decided to play for Guy's, and had a successful season with the bat. The bowling was strengthened by J. Butchey, a leg break bowler from the West Indies. Butchey also had a good season as opening bat.

On several occasions in the latter half of the season, Guy's batted well, particularly the 260 for 6 against the Madhatters on the county ground at Tunbridge Wells, and 170 for 1 against Streatham. However, earlier on the side was often dismissed for about 100, and this is not enough to win first class club matches.

What proved the greatest stumbling block to winning matches was the fielding. Time and again vital catches were put down, and this caused Guy's to lose matches, and prevented them from winning more. The most unfortunate occasion was against Bart's in the cup. Having easily beaten King's in the first round, and made 160, we had Bart's struggling at 97 for 6. A catch was put down and Bart's won the match without losing another wicket.

Eight of this year's side will be here next year, and if there is amongst the freshmen a fast bowler and a wicket-keeper, next year's side should be a good one. Hamish McGregor, after seven seasons in the team, has qualified, and his absence behind the stumps will be felt. We wish him the best of luck.

BLUES COMMITTEE

At a recent meeting of the Blues Committee, the following awards were made:—

Rugby—Full Blue: D. R. Bevan, A. R. Fisher, A. J. Kingdon. Half-Blues: A. J. Allan, M. Cockburn, N. James, A. M. Morris, J. Ross, B. Rowlands, H. Sharp.

Association Football—Full Blue: E. Elias, J. Cochrane.

Hockey—Full Blue: C. Brooks. Half-Blue: J. Crafts, R. Carruthers, S. Rear.

Boxing—Full Blue: T. Gibson. Half-Blue: W. Onyeama, H. Bethell, K. Hughes.

Golf—Full Blue: M. Brummitt, D. Adams. Half-Blue: B. Bevan-Jones, G. Williams.

Squash—Half-Blue: J. H. Newman, C. L. Newman, J. R. Webb, E. P. Davis, P. S. Hughes.

Boats—Full Blue: C. A. C. Pickering. Half-Blue: P. Burton, A. Green, A. Hodgkinson, M. Preece, P. Sharp.

LADIES' TENNIS

This year Guy's Ladies' Tennis Team capped a highly successful season by winning the United Hospitals' Tennis Cup—the first time we have won the competition for many years.

The success of the side has been mainly due to the availability of eight players who have all maintained a high standard of play throughout the season, namely Anthea Sutton, Priscilla Heather, Penny Heather, Janet Hock and Clare Stevenson from last year's team. With the addition of three very good freshers —Philippa Bevis, Linda Barnett and Hilary Hodge.

The side has been unbeaten this season and each match has been won by a considerable margin.

On the way to the final, Guy's beat the Middlesex, the Royal Free, and King's College Hospital, with the loss of only three matches.

The final was played against St. Thomas' Hospital at Cobham. They had not had such an easy path to the final, and were handicapped by having a second and third couple who were of much lower standard than the first, whereas the Guy's couples were of more equal ability. The final score of 5—1 was indicative of the superiority of Guy's over the other London Hospitals this season.

CRICKET

With the Guy's cricket season drawing to a close (only the tour of Sussex and two August matches remaining), the team has been having a successful run. The Nomads were fairly convincingly beaten, being bowled out for 120 on a lively wicket at Honor Oak Park (of which there have regrettably been far too many this season). As the pitch dried out it eased somewhat and only four wickets were lost in scoring the runs.

A late start was made against Streatham because of rain, but the late start was more than compensated for by the aggressive batting of Guy's. McGregor's was the only wicket to be taken, but not before he had scored an accomplished 49. Butchey hooked menacingly to score an unbeaten 62, and Silk (55 not out) also administered heavy punishment, so that Guy's were able to declare at 174 for 1. In reply Streatham were 19 for 2 when the rain came.

Midweek, a combination of 1st XI and 2nd XI won a very exciting match against Thornton Heath by seven runs. Crafts (53) and Powell-Jackson (40) were the backbone of the Guy's innings, which produced 157. Thornton Heath had scored 93 for 2, but then a devastating spell of leg break bowling by Butchey (7 for 62) was aided by magnificent catching. R. Brown caught the last man when they were only seven short of the Guy's total.

The Mote, one of the strongest clubs in Kent, took nearly three hours to make 153. Beacham bowled well to take 4 for 58, and Silk, who was put on to bowl sometime during the third hour to try to brighten the proceedings, took his first wicket ever for the Hospital.

Left two hours, Guy's were rather slow in the first hour, in spite of a rapid 22 by Cutler, and the batsmen perhaps left it a little late before going for the runs. Nevertheless, 147 for 6 was the final score—only six short.

J. R. CRAFTS

HOSPITAL INFORMATION

GUY'S HOSPITAL MEDICAL SCHOOL

Applications are invited for the post of **Assistant to the Director of the Paediatric Department,** with duties to commence as soon as possible. Initial salary according to qualification and experience. Forms of application are obtainable from the Dean, Guy's Hospital Medical School, S.E.1, and should be returned to him not later than **18th August, 1965.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Registrar in General Medicine,** with duties commencing 1st October, 1965, and appointment for one year in the first instance. Application forms are available from, and should be returned to, the Superintendent, Guy's Hospital, London, S.E.1, not later than **14th August, 1965.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Registrar in the Department of Clinical Pathology,** with duties commencing as soon as possible and appointment until 30th September, 1966. Application forms are available from, and should be returned to, the Superintendent, Guy's Hospital, London, S.E.1, not later than **14th August, 1965.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Registrar in Radiotherapy,** from 1st October, 1965, for one year in the first instance. Forms of application are obtainable from the Superintendent, Guy's Hospital, S.E.1, and should be returned to him not later than **21st August, 1965.**

GUY'S HOSPITAL, S.E.1.

Applications are invited from registered dental practitioners for the appointment of **Full-time Senior Registrar/Registrar in Clinical and Oral Surgery,** with duties to commence on 1st October, 1965. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, London, S.E.1, not later than **Friday, 20th August, 1965.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Research Associate in the Cardiac Department,** with duties commencing on or before 1st October, 1965. Salary in the range £1,425 p.a. to £1,595 p.a. with superannuation, according to experience. Application should be made, on a form obtainable from the Dean, by **14th August, 1965.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Heart Foundation Research Fellow,** commencing 1st October, 1965. Applicants should be interested in immunological disorders and in homograft reactions, but need not have had previous experience in this field. The work is mainly immunological, but includes a follow-up of patients, who have had homograft replacement of the aortic valve, and some clinical duties.

The appointment is for a year in the first instance, at a salary of £1,195 to £1,425 per annum, depending on experience. Applications should be made not later than **Monday, 16th August,** on a form to be obtained from the Dean, Guy's Hospital Medical School, S.E.1.

THE ROYAL MARSDEN HOSPITAL, SURREY, BRANCH DOWNS ROAD, SUTTON, SURREY

Applications are invited for the post of **Resident House Officer (Radiotherapy) with Surgical Duties.** Senior House Officer Grade. This is a Post-graduate Teaching Hospital—a Radiotherapy Centre with high energy apparatus and 99 beds. The appointment will be for one year. Application forms can be obtained from the Administrator, to whom they should be returned as soon as possible.

PASS LIST

PRIZE EXAMINATIONS
EXAMINATION FOR THE NEWLAND PEDLEY MEDAL AND PRIZE FOR OPERATIVE DENTISTRY
June, 1965

The following awards have been made:—
Medal and Prize to R. D. Johnson.
Certificate to Miss S. Parry.

DAVID FRANK STURDEE PRIZE
July, 1965

The following awards have been made:—
First Prize to J. K. Skuse.
Second Prize to Miss L. J. Sayles
Certificate to Miss A. B. Lysholm.

NURSING NEWS

The following Nurses passed the Final State Examination held in June, 1965:—

Blaber, C. A.
Boddy, R. E
Brice, A. B.
Coombe, A. G.
Cousins, S. A.
Curry, J.
Dodds, S. W. R.
Ducker, G. M.
Evans, E. G.
Ewels, M. R.
Ford, M. A.
Gibson, B. D.
Gunn, M.
Hainsworth, J. A.
Hawkes, M. R.
Hetherington, C. P.
Heyworth, C. M. V.
Hill, R. E. A.
Hoad, E. F.
Kirby, D. K.
Lacey, J. A.
Lennie, S.
Lewis, D. M.
McCowan, G.
Marigold, J. R.
Marshall, J. A.
Martin,, D. J.
Matthews, K. L.
Mawson, C. A.
Mumford, E. A.
Newman, M. A.
Page, A. D. C.
Paxon, E. A.
Pitt, M. S. K.
Rawlinson, P. M.
Ritchie, B. K.
Smith, J. M.
Stair, B. J.
Stevens, S. C.
Treutler, G.
Turner, J. M. P.
Tyley, A. A.
Wall, G. L.
Waters, J. M.
White, D. G.
Whitehead, E. A.
Williams, M.
Woodward, G. D.
Wrench, H. L.

Combined Training with Moorfields Eye Hospital, E.C.1.
Benton, S. Dudley, H. M.
Combined Training with Nuffield Orthopaedic Centre, Oxford.
Mantell, A. M. Tolhurst, A. J.

SMALL ADVERTISMENTS

Bournemouth, two Guy's Dental Surgeons with progressive conservative practice hope to replace colleague who is leaving well staffed and equipped practice. Box No. 20.

Is any Dental Surgeon, or student about to qualify, interested in working in a well equipped and staffed practice in Pinner? Own laboratory. Opportunities for the very best work. Tel. Pinner 2299, or write Box No. 21.

Young Guy's man requires assistant in a friendly dental practice in Hunts market town, 50 miles from London. Equipment eighteen months old. Plenty of work and excellent remuneration for young colleague practising hospital standard dentistry. Box No. 22.

Blackheath. Furnished house to let for one year from October 1st. Three bedrooms, garden, garage. Tel. Lee 7704.

CHANGE OF ADDRESS

Doctor and Mrs. J. P. Lissenden, 6, The Avenue, St. Clements, Jersey, C.I.

Doctor and Mrs. M. Bradshaw, 66, Dale Hall Lane, Ipswich, Suffolk. Tel. Ipswich 55791.

BIRTHS

ASHBY.—On 15th July, 1965, at St. Bartholomew's Hospital, E.C.1, to Kathleen (née Allsopp) and Peter Ashby, of 2, Lesley Court, Strutton Ground, London, S.W.1, a son.

ADOPTION

McCORMACK.—By Madeleine (née Thompson) and John McCormack, of St. Mary's Cottage, Hardwicke, Aylesbury, Bucks, a son, Dominic John.

DEATHS

LLOYD.—Edgar Allan Lloyd, L.D.S., R.C.S., aged 75 years, on June 21st, 1965, at his home, Three Hollies, Brilley, Hereford.

McKITRICK.—Ethel Margaret (Guy's 1908), aged 82, on June 14th, 1965, at Johannesburg, South Africa, after a short illness.

PYE-SMITH.—Charles Derwent Pye-Smith, D.S.O., M.C., F.R.C.S., of West Bank, Bakewell, Derby, on 24th July, 1965, in St. Luke's Hospital, Huddersfield, at the age of 86.

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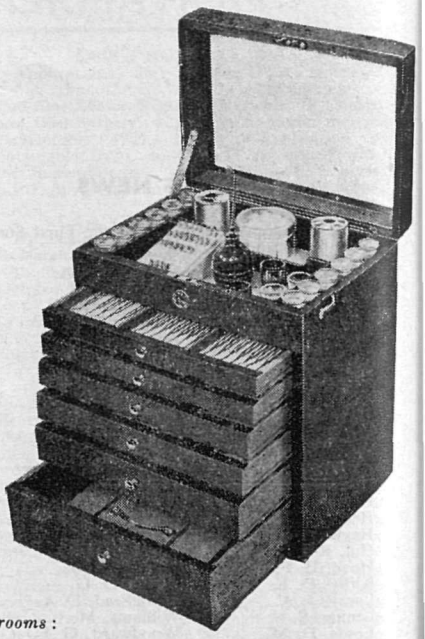

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GUY'S HOSPITAL GAZETTE

FORTNIGHTLY ONE SHILLING VOLUME 79 NUMBER 2011

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EDITORS P. BOWDEN AND A. E. RAYNES
SPORTS CORRESPONDENT A. PROCTER

GUY'S HOSPITAL, LONDON

Limelight

In spite of the inherent trials and tribulations of studentship, we are fortunate to be serving our apprenticeship at this particular stage in the metamorphosis of medicine. Some entered the course with only a fragile idealism which was shattered at the first *viva voce* examination, while others have never really thought about the science that they studied in any other than a parochial light.

The Press is full of us and we have overflowed into the colour supplements which are down to quoting doctors' wives' hallowed epithets. There are cryptic morals from near-emigrating pathologists, the sighs of tired surgeons and a photograph of bracken growing out of the hospital gutters that were once workhouse gutters in the days before nationalisation. All facets from medical education to the very nature of our art are receiving scrutiny. The journalists have made sensation of us and the leaders of faculties and the union bosses have made ample representation. We have seen conflict, reason and stupidity. Doctors are news nowadays.

Now we are discussing medicine and rationalising our motives, wondering exactly what we want of it all and what we are prepared to give.

We may want to return to pre-N.H.S. days, a time that we never knew but of which we have been made aware, or we may belong to the disillusioned many who require fresher pastures. The important fact is that we have thought. The last few months have dispelled the complacency of our studentship and we have become more aware of our lot. At least we find our relationship to the fence by design not accident.

Dr. John Fleminger has been awarded fellowship of the Royal College of Physicians.

Mr. R. Y. Calne, senior lecturer and honorary consultant in surgery at the Westminster Hospital, has been appointed professor of surgery at Cambridge University. Mr. Calne qualified at Guy's in 1953.

Dr. A. N. Davison, reader in biochemistry at Guy's, has been appointed to the chair of biochemistry at Charing Cross Hospital Medical School.

Dr. Alfred Robinson has been appointed Consultant Paediatrician to the Chichester, Graylingwell and Worthing Hospital Groups.

Channel revisited

During the last three weeks, two enormous holes have appeared in the ground around New Guy's House. Although surmounted by winches and tended by helmeted workers, any ideas of oil prospecting by our versatile works department can be dispelled by closer scrutiny. These are two busy archaeological sites.

The excavations worked by amateur enthusiasts are directed by M. R. Maitland Muller, Keeper of the Cuming Museum. It is hoped that the dig will expose parts of the Roman Channel that runs from the Thames southwards beneath New Guy's House. Evidence of the position of this channel was reported in the *Gazette* of 1889, when an old wooden barge was discovered during the digging of the foundations of a warehouse adjacent to the College. Work on the foundations of New Guy's House in 1958 revealed part of a Roman boat, which was estimated to be forty to fifty feet long.

Both of the present sites have shown evidence of 17th to 19th century occupation at the higher levels but as yet the Roman channel has not been found. It is interesting that several large bullock horns have been unearthed in this present dig, as it was reported in the *Gazette* of 1889 that "some five or six thousand bullock horns were unearthed, forming a rather extraordinary treasure trove with an unexplained history."

Any Guy's people who are interested will be most welcome to help in the excavations. They are invited to contact Mr. Maitland Muller on the site. The dig will continue until September 4th.

The elegant buildings, in St. Thomas's Street have been redecorated and bring to mind the words of Keats :

> "Vermillion—spotted, golden, green and blue;
> Striped like a zebra, freckled like a pard,
> Eyed like a peacock, and all crimson barr'd".

Professor R. H. S. Thompson has been appointed Director of the Courtauld Institute of Biochemistry at the Middlesex Hospital.

Dr. S. Cohen, Reader in Immunology, St. Mary's Hospital Medical School, has been appointed Professor of Chemical Pathology at Guy's.

The Council of the Royal College of Surgeons of England awarded the Handcock Prize to G. A. Pettitt in the Conjoint Examination.

THE PLACING RESPONSE and PRIMARY WALKING

R. C. MAC KEITH

(*Based on a paper given at the Medical Research Society, March* 12, 1965)

The neurology of the first year of life has received increasing attention in recent years. Albrecht Pieper, in Leipsic, has been studying it for many years. The great French neurologist, André-Thomas, was so intrigued by the many responses of an anencephalic that after retiring at the age of 75, in 1945, he devoted the next 20 years of his life to studying, with the assistance of Madame St. Ann Dargassies, the normal infant's performance.

In the special study of the neurology of the newborn, the work of Heinz Prechtl, of Groningent, is epochal. On another front, paediatricians, notably Richmond Paine, of Washington D.C., are attempting to diagnose cerebral palsy in the early months of life and the results of early treatment along lines suggested by the Bobaths in London, Milani in Florence and Köng in Berne, seem likely to prove a considerable advance.

At birth, the infant shows a general high level of flexor postural tone and a variety of postural responses. In the next four months, many of these disappear; e.g., tonic finger and toe flexion, the supporting reaction, primary walking, moro response. From the fourth month various definitive skills appear, e.g., prehension, head control, turning to sound, following with the eyes. Because many of the neonatal reactions have by then disappeared, but few definitive reactions have yet appeared, the third and fourth months are months of relatively few reactions. On the other hand, if there is cerebral dysfunction, primitive responses may persist into this period and abnormal postures may emerge, commonly abnormal chiefly by the age at which they are present—e.g., the hemiplegic hand shows "fisting" after the age at which this has usually disappeared.

Today, routine examinations of the infant includes closer analysis of some of the various postural responses:—

Supporting, placing responses, primary walking.
Tonic labrinthine responses.
Asymmetric and symmetric tonic neck responses.
Righting responses and equilibrium responses.
Parachutist response.

The paediatrician who studies the infant has to know the normal responses of a large number of different "animals", the immature, prematurely-born infants of various ages, the newly-born full-term infant, the infant of 1, 3, 6, 9 and 12 months and so on. Further, he

realises that to say dogmatically that "normally" a response is or is not present at a certain age is over-simplifying. He would like to know the probabilities of it being present and he needs to know, if possible, whether he may expect it to be well marked, medium, minimal or absent.

We read in Illingworth (1963) that the small child "walks without help at 13 months", but the same author also refers to a child who walked unaided at 8 months (his I.Q. at 5 years was 88) and to another who could not walk without help till 4 years old, although she had no physical disability and her I.Q. at age 5 was 125.

The invaluable developmental tables of Gesell, Illingworth and Mary Sheridan give no indication of the numbers of children observed, nor of the proportion who, in fact, achieved the various responses and skill at the ages listed. One of these days we shall have tables giving the range of normal as well as what are presumably mean values.

PRESENT WORK

This report is made partly to describe an approach and report a pilot study, but mainly to put certain questions arising out of an unexpected observation.

In the course of routine Infant Welfare Work, I made observations on the placing reaction and on primary walking. The 'state' of the infant was not noted and the testing was not repeated on another occasion, but while these are deficiencies in my limited observations, only Prechtl has so far published observations adequate in this way.

THE PLACING REACTION

(réaction d'enjambement, reactione d'appogio)

The child was held up under the arms and his feet brought under the table edge. The usual response is for the infant to "step over the kerb". This "placing reaction" was observed and rated +3, +2, +1 or 0.

The placing reaction is known to be present throughout the first year (except where there is paresis or gross intellectual handicap) but I know of no reports of the variation in its vigour with the age of the infant.

RESULTS OBSERVED

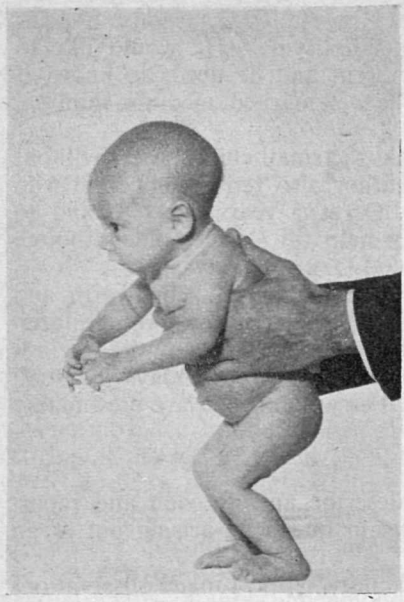
of infants up to and including the age of 4 weeks:
20/20 showed placing: average rating 2

of infants 5 to 12 weeks:
26/30 showed placing: average rating 1.3

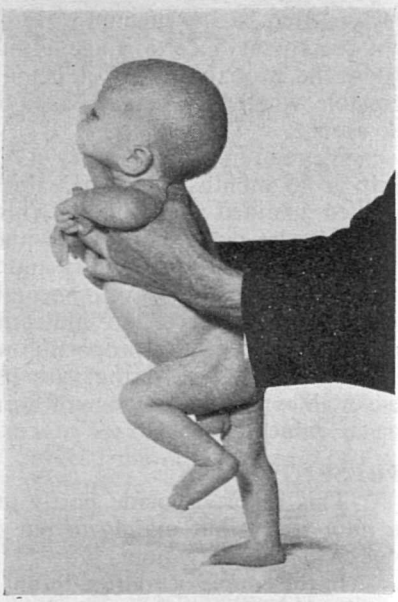
of infants 3 months to 11 months:
8/10 showed placing: average rating 1

CONCLUSION:

These preliminary studies suggest the placing reaction is normally a good deal more vigorous in the first few weeks of life. Why should this be so? Perhaps this is due to the overall high degree of flexor tone which the infant has at this period.



Child, aged 9 weeks, in vertical suspension, feet on table : no primary walking.



On passive extension of the head, primary walking occurs.

PRIMARY WALKING

After the child had "stepped over the kerb" in the placing reaction, his feet were lowered onto the table top. His response is to straighten the lower limbs in a "supporting reaction". His trunk was then leaned forward and he commonly took steps forward. This is reflex or primary walking. The presence and quality was rated +3, +2, +1, or 0.

Albrecht Peiper, in his film on the development of walking (of which we hold a copy) has a charming sequence showing an infant of a few weeks old, supported and walking across a table top and then up a little flight of stairs, then up the wall, across the ceiling, down the other wall where he meets another stair which he once again successfully surmounts.

To what age does this response of the newborn persist? Stirniman (1938) says it goes at the fourth to fifth month. Illingworth (1963) says that "the walking reflex disappears by the age of 2 to 3 weeks". Madame St. Anne Dargassies taught me that it lasts for 4 weeks. Mary Sheridan (1960) says it is present at 4 weeks and gone at 2 months of age. Benedetti (1958) reported that primary walking appears and disappears earlier in infants born by normal delivery than after difficult labour or neonatal asphyxia.

Primary walking is a myotatic spinal reflex (Sherrington 1910). New-born human infants and spinal adult animals can walk if supported. New-born rabbits in which the dorsal cord has been severed,

move about immediately after the operation, in contrast to adult animals in whom the hind limbs remain paralysed (Spatz 1927). Philipson's reflex in patients with division of the spinal cord presumably uses the same neural patterns as primary walking.

RESULTS OBSERVED

of infants up to and including the age of 4 weeks:
18/22, 82 per cent showed primary walking:
average rating 2

of infants over 4 and under 8 weeks:
7/12, 54 per cent showed primary walking:
average rating $1\frac{1}{2}$

of infants of 8 weeks and over:
4/34, 12 per cent showed primary walking:
average rating 1

CONCLUSION:

These few observations indicate the need for more detailed observations of larger numbers of infants. It is, however, possible to say that under the age of 4 weeks, 80 per cent of infants showed primary walking and of infants between 4 and 8 weeks 50 per cent showed it and of infants between 8 weeks and 11 months (none with gross neurological disorder) 1 in 8 showed primary walking.

THE EFFECT OF PASSIVE HEAD EXTENSION ON PRIMARY WALKING

Once upon a time, playing with a baby, I noticed that when I lifted his head, vigorous primary walking occurred. So in this series, after observing whether the supported infant showed primary walking or not, I went on to observe the effect of passive head extension. With the forefingers of the two hands by which the infant was held round the trunk to support him, I pushed his chin upwards. In many of the infants observed there was an increase or appearance of primary walking. The vigour of the primary walking was once again graded 0, 1, 2 or 3.

RESULTS OBSERVED

of infants up to and including 4 weeks of age:
passive head extension produced an effect in 13/19, i.e. in 68%.
9 showed increased primary walking
average increase 1.8 points.
4 flexion of both lower limbs.

of infants 5 to 8 weeks of age:
passive head extension produced an effect in 8/11, i.e. in 73%.
7 showed increased primary walking
average increase 1.5 points.
1 showed flexion of both lower limbs.

of infants 8 weeks to 11 months:
passive head extension produced an effect in 26/33, i.e. in 79%.

24 showed increased primary walking
average increase of 1.8 points.
1 showed flexion of both lower limbs.
1 showed flexion of one lower limb.

In Summary: in infants 0 to 11 months old:
passive head extension produced an effect in 47/63, i.e. in 75%.
40 increased primary walking.
6 flexion of both lower limbs.
of the 6 who developed bilateral lower limb flexion
4 had just previously shown very brisk primary walking.

Discussion of this effect of passive head extension

Primary walking is a spinal reflex. Primitive patterns mediated by spinal centres seem to be commonly integrated into later definitive responses. It should perhaps be noted that definitive walking probably need not be a learned response. Peiper has described a child kept in plasters or splints from 6 months old; one night, when he was 18 months old, the splints fell off and the child walked into the parents bedroom.

Question 1: Why does passive head extension at all ages during the first year commonly evoke reappearance or increased vigour of primary walking?

In the **Laudau reaction** (Mitchell 1963) which is often present from 12 weeks, and present in the majority of infants in the second half of the first year, spreading of extensor phenomena is seen. The infant is held in ventral suspension; when he extends his head, the spine extends and the lower limbs extend at the hips. Sometimes the whole of the lower limbs and the upper limbs extend. (Passive flexion of the head will cause flexion of the spine, the upper and lower limbs. In Brudzynski's third sign of meningitis, passive head flexion causes flexion of the lower limbs. This may be a revival of an infantile response.

The "pool of extension (or flexion)"

Active extension (or flexion) of one part will often lead to extension (or flexion) elsewhere. This is understandable as a spread of extension in an immature (or injured) nervous system. In children, opening the mouth is commonly accompanied by extension and separation of the fingers. Physiotherapists induce flexion of trunk and limbs by passive flexion of the head when they wish to control extensor spasms in cerebral palsied children. Fog's reaction from feet to hands is an example. (Fog 1963).

Milani says it matters little whether the addition is an active or a passive one since, in either case, the result is "an addition to the pool of extension". I can easily understand extension of the limbs following active head extension by a process of spread, but I only accept the same effect of passive extension; I do not feel that I understand it.

The increase of primary walking which is seen on passive head extension can be expressed in other words by saying that primary walking is essentially an extensor pattern and so additions to the extensor pool will stimulate its appearance or its vigour. In an

analogous way, Milani describes the asymmetric tonic neck response as being an extensor pattern although it clearly includes flexion of the (occipital) limbs as well as extension of the (face) limbs. This seems probably reasonable in that the asymmetric tonic neck response is present in premature infants in whom flexor tone is weak, absent in the first month or so of life when flexor tone is strong and present again during the third and fourth months when the neonatal phase of flexor tone has passed off. But, of course, to describe primary walking as an extensor phenomenon does not explain it; it only states an observation in other words.

Question 2: If primary walking is essentially an extensor pattern, why is it that sometimes passive head extension causes bilateral lower limb flexion? Especially as this seems to happen more commonly where primary walking has been especially well marked.

The symmetrical tonic neck response deserves mention here. In the decerebrate cat, when the head is flexed, the forelimbs flex and the hind limbs extend (the cat "looks into the mouse hole") and when the head is extended the forelimbs extend and the hind limbs flex (the cat "looks up at the table and prepares to spring"). Freundenberg (1921) is quoted by Peiper (1963) to the effect that in normal infants flexion of lower limbs on passive extension of the head may be seen.

I am a little doubtful about transferring observations made on mutilated cats to normal human infants. Milani says the symmetrical tonic neck response is present in infants during the second six months of life but I saw the bilateral lower limb flexion as a response to passive head extension several times in infants of about a month old.

The most intriguing point is that it was above all when primary walking had been brisk that passive head extension led to flexion of both lower limbs. To put this in other words, when primary walking was already maximal, the change produced by passive head extension was flexion to both lower limbs. Is the extreme degree of primary walking bilateral lower limb flexion? If so, can primary walking be described as essentially an extensor phenomenon?

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Patients are a Virtue

L. A. DIEHL

Did I ever tell you about my experiences in Out-patients? I did? —then I'll tell you again. Things had got pretty desperately uncomfortable when I rang the hospital and asked for Appointments and told the dear girl that I wanted a date with the Professor p.d.q. She listened quietly, flicked over the pages of the Appointments Register and gave me a firm date in a firm voice—about a month ahead; so I told her I couldn't wait that long and could she transfer the call to the Mortuary as there was much to arrange—there was a strained pause and, to give the girl credit, she told me the line was dead! . . . . then she relented and I came next day.

I entered the familiar building with its clean smell and air of brisk attention, was directed to a long bench already filled with resigned customers who made half-hearted little movements up and down as though to make room for me, without making any appreciable part of the bench appear for me to sit on. As I was considering whether to crowd in at one end and put the dear old lady at the other end in peril, the Staff Nurse relieved the pressure by removing some of the benchers to more mysterious places.

There is an air of bemused panic in Out-patients—heaps of X-rays and Case notes are shuffled at high speed, people's names are called and no one answers, bells and buzzers blurt forth and no one answers, junior student nurses scurry about suffering from anxiety neurosis while the patients are patient. Head Nurse gazed at me severely—I was not expected, who was I, and they hadn't got my notes or X-rays—which all sounded pretty depressing. I was non-U straight away because I couldn't produce an appointment card or, horror of horrors, a letter from my doctor. I felt a bit dashed that no-one knew me; after all, I'd spent nearly two years out of the last three in the place and I felt that I was entitled to consider myself a regular rather than a casual customer . . . so I explained. So I was weighed, heaven knows why, then I was temperatured and this was discovered to be on the low side. I suggested that perhaps I didn't feel so hot . . . dead silence. So then I was measured up against the wall in spite of my protests that at my age I was unlikely to have grown and, as we always used OHNO, unlikely to have shrunk—all to no avail, they did it anyway, and by the way would I mind spending a penny. About five minutes later I was reminded gently that I was going to spend that penny; not to be outdone, I replied equally gently that I'd done that small thing, the measuring jug was on the shelf. She did a cross between a shriek and a giggle and said "Oh, was that yours. We threw that away—could you spend another penny?" The reason for the looks of resignation on the faces of the patients became more apparent—so we scrubbed round that part and I sat.

Then I sat some more; they were looking for my notes and X-rays.

The old trout next to me went into complete clinical details of her complaint and subsequent operation—I shuddered and told her I didn't spik Inglish so good. A couple of old friends came in, saw the doctor and left again—they still hadn't found my notes. I did suggest that my case was as well known a one as you were likely to get in a Teaching Hospital, and that most of the doctors present could probably produce my case history from memory—but no—orders were that it was notes or nothing—so I sat.

Then the X-rays turned up. I was overjoyed; I had justified my existence, but Head Nurse was unimpressed. "No chest X-ray." I explained that I had a bad foot and a chest X-ray was unlikely to be relevant. A fatal mistake that, my feet hardly touched the floor between there and the X-ray department, where I, with dangling braces and goose-pimpled arms " had me photo took " with my chin jammed in the air on a metal bar, in a posture that would have done credit to the Common Victoria Pigeon, but what worried me was why, if there was nothing lethal about the business, everyone scuttled off into a little lead-lined room and left me exposed to all those purple and yellow fireworks.

Eventually I did get to see the doctor, but not before Nurse and I had a stand-up fight on the subject of "getting ready." She wanted me to strip down to the waist and all that caper, whilst I pointed out that I'd got a bad toe and as a concession I was prepared to take one shoe off—and that was my lot. Then I endured a homily on the subject of wilful and unco-operative patients while I sat with my lips pressed firmly together, clasping my pants to me and flatly refusing to remove them.

So the doctor saw me, didn't care whether or not I'd spent a penny, wasn't interested in my weight, height or temperature, didn't want me to take my trousers off and was quite unconcerned that my notes couldn't be found. We jawed of this and that, and then he said, by the way, how's the foot, and I said, you'd better have a look, and he did, and then I came out again into the world where gynaecocracy is imposed upon a bewildered public. Head Nurse reluctantly allowed me to go with obvious misgivings. I looked sorrowfully round at the unfortunates remaining there, half-dressed, desperately uncomfortable and embarrassed, staring fixedly at a poster giving fascinating details of the colours to be found on various gas cylinders or what to do in case of fire—decided there was not much I could do to cheer them up—and left.

On the way out, wearing my vague look, I met the Outpatients' Sister who immediately pounced—obviously I was a patient in need of care and attention, lost and liable to wander into Routine Isotopes without Proper Preparation. She enquired in a gravelly voice where I thought I was going. Now this staggered me a bit because I hadn't given the matter much thought—vaguely "Home" I suppose, so I recited the Christopher Robin one about the Bears and the Squares—the lady was most impressed. She took my arms firmly from behind and told me in a soothing gravelly voice that everything would be all right, which I doubted.

This is a nice room with padded walls and ceiling . . .

CORRESPONDENCE

Peter in A

SIR, With customary virtuosity, your correspondent in your last issue entertained us with his observations on the editorial headline over my article. It distresses me a little that his interpretation of its symbolic content suggests that Peter is already in an asylum, though who knows his power of prophecy. He may have missed one alternative, namely that A being the note to which the orchestra tunes Peter was in hopes of acting in some measure as a guide to others on the subject matter of his article.

As for "handicapped Gardiner children", it appears that the term "handicap" derives from a lottery where chances are taken out of a hat. This is appropriate not only of course to these particular Gardiner children, but to all. The geneticists may be able to throw some light on why a child is who he is, but to the child the gamble, of which he is the jumbled result, is the determinant.

The purpose of my article was to try and calculate the odds in some children so that they can be extracted from the pools and join the mainstream of development.

May I congratulate the Editor on his intuitive lay-out and remind Dr. Vertue of the paradox that now as ever *PANTA REI*.

Yours etc., PETER A. GARDINER.

Guy's Hospital,
London, S.E.1.

Peter in A Jumble

SIR, Having recently had an article, "Music and Everyman", published in the *Gazette*, spoilt in my opinion by one of those "jumbles" so frequent in the *Gazette*, I was able to appreciate Dr. Vertue's ironical comment in your last issue. To pay a professional typist to produce a flawless copy of an article, and then to have it "jumbled" when it appears in the *Gazette* fairly makes one rage. One will say nothing of the literary solecisms of all kinds, e.g., "salutory" for "salutary" and a few more which not infrequently appear in the Passims of *some* Editors. They only make one wonder whether English isn't perhaps the last of the qualifications asked for in an aspiring Editor.

Yours, etc., G. L. DAVIES.

Oakfield,
Hay-on-Wye,
Hereford.

The second line of Dr. Vertue's letter in the last issue of the Gazette *was jumbled and should have read, "Eye disorders Peter in A." and not "Eye disorders, Peter in A".*

Total Medical Care

SIR, I was much interested in your leading article on "Total Medical Care", which is full of excellent good sense. But what is this about Medical Schools that are "organising compulsory attachments to General Practitioners"? On whom is the scheme compulsory? On the student, one supposes, but also it would seem on the General Practitioner? If so, and I were a G.P. myself, I know in just what forcible language my reply would be. And yet a third party is added to the compulsion—the patient, who is not to be allowed to interview her doctor privately but in the presence of a student. This state of affairs may be tolerated (and it *is* only toleration) in a teaching hospital, but I am quite sure of what a G.P's patient would think of it.

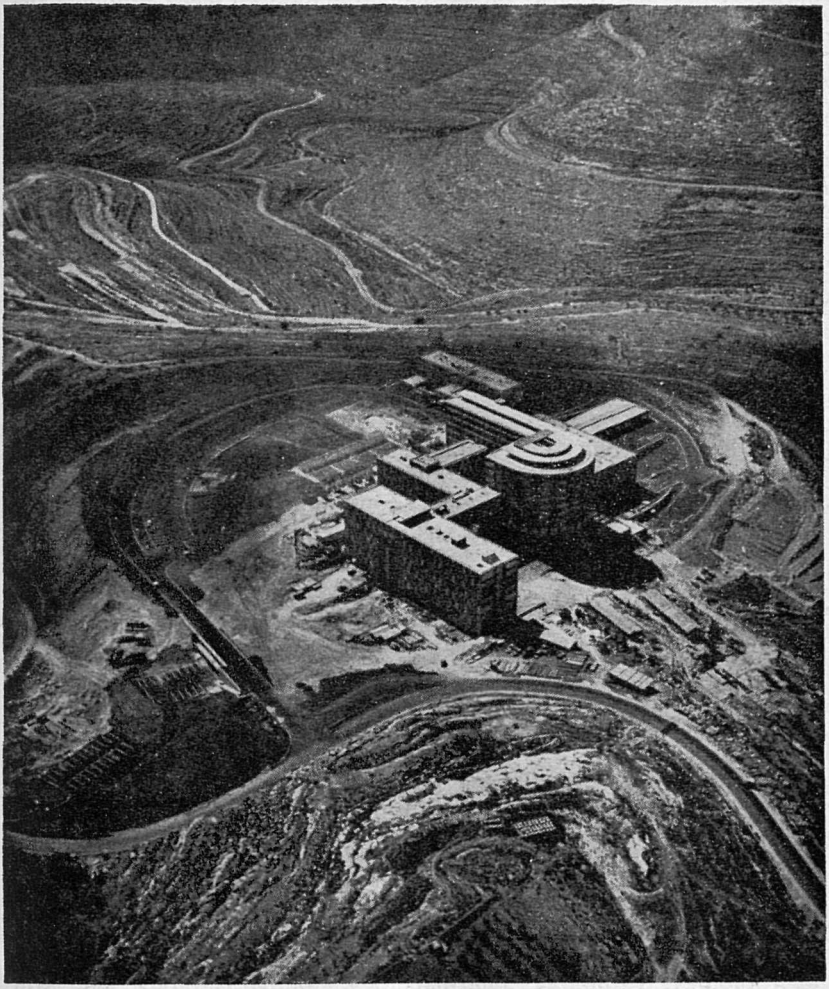
Presumably, too, this compulsory spell would be in addition to the ordinary six years of study, and to the other imposition of compulsory house appointments. The latter at least have the advantage of bearing some small pay attached to them, but would the student be paid for the compulsory attendance on a G.P.? The answer from Bernard Shaw's "Pymgalion" is only too appropriate.

Yours, etc., J. W. SHACKLE.

14, Moneyhill Road,
Rickmansworth, Herts.

MEDICAL CARE IN ISRAEL

by Susan Kramer



THE NEW MEDICAL CENTRE NEAR EIN KAREM.
(reproduced by kind permission of Professor M. Prywes.)

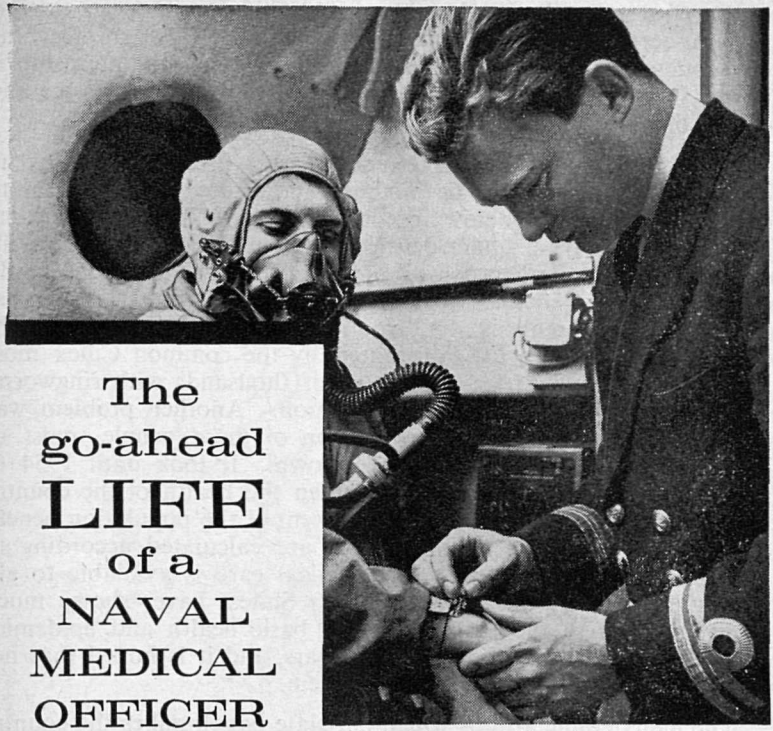
High above the ancient monastery village of Ein Karem (Jerusalem) a vast complex of buildings stand on a plateau carved out of the Judean Hills. This, the Hadassah-Hebrew University Medical Centre is one of the youngest medical faculties in the world, and behind such an edifice lies a story of human ingenuity and effort.

In 1912, an American social worker Henrietta Szold, persuaded a small group of Jewish women to dispatch medical aid to their brethren in Palestine, which was then an under-developed land rampant with disease and suffering. They accepted the challenge and sent out two trained nurses who did pioneer work amongst the Jewish, Moslem and Christian population of the Old City of Jerusalem. From this small group has sprung a nationwide organisation called Hadassah, through whose efforts hospitals, teaching institutions, preventive and public health services have been established in Israel.

Although 1947 saw the inauguration of the first Medical School on Mount Scopus, outside Jerusalem, the following year brought the War of Independence, during which enemy forces gained control of the road leading to the Centre. An Arab ambush on a convoy taking doctors, nurses and patients from the city to Mount Scopus resulted in the death of seventy-six of the hospital staff and movement along the road soon became impossible. The hospital, one of the finest in the Middle East was closed and has never been re-opened, for the United Nations decided after the war, that the area was to become a demilitarized zone, and now the hospital stands derelict and unused. But Hadassah fought on and in 1961 a new Medical Centre was completed within the new frontiers. From a structural and functional viewpoint, the Hospital and Medical School are inseparable, the two being joined by a U-shaped wing containing the clinical-diagnostic laboratories, and providing the closest possible relationship between the teaching, research and clinical activities conducted by the Medical Staff.

Although Israel enjoys the highest ratio of doctors in the world, the profession is cosmopolitan, comprising immigrants from sixteen different countries. Every group has brought with it the knowledge and working habits of its country of origin, and the actual profile of the Medical Faculty is thus a synthesis of the combined experience of many backgrounds. It is, however, very difficult to become a medical student in Israel, since there are only sixty admitted to the faculty each year and twenty of these are from the newly-developing countries in co-operation with the World Health Organisation.

The medical course covers a period of six years of study, including a premedical course of eighteen months with compulsory study of the humanities. Pre-clinical students start with anatomy, and this is followed in the next two and a half years by physiology, biochemistry, microbiology, pathology, pharmacology and parasitology; and still later by courses in physical diagnosis, social medicine, psychiatry and even nursing. During the first clinical year the students work in rotation in the hospital wards as clinical clerks, whilst in the second clinical year they rotate in the various out-patient departments and work in the family health centres. They are encouraged to spend their



The go-ahead LIFE of a NAVAL MEDICAL OFFICER

A pilot being prepared for a simulated high altitude test.

This is a life of unbounded opportunity. Anywhere in the world, you practise medicine with complete medical freedom. Among 100,000 Naval men and women you gain extensive medical experience of the most varied nature. Civilian patients, too, of both sexes and all ages, are treated in Naval hospitals. You have excellent opportunities for specialising in the normal clinical subjects, and in the less usual, such as Nuclear, Underwater, and Aviation medicine. You are actively encouraged and financially assisted to acquire higher degrees. You can gain consultant status.

As a Medical Officer, your pay, allowances, and gratuity—or permanent commission pension—are very good: for example, your initial pay is considerably higher than that of a civilian hospital registrar.

You can enter in one of three ways: as a registered Medical Practitioner — your *civilian experience back-dating seniority*— or as a qualified doctor doing your pre-registration year, or as a student with a 2nd M.B. For qualified women doctors, there is a special short service commission. For fullest details of your Royal Navy life as a Medical Officer, write, mentioning your own qualifications and age to:

The Medical Director-General of the Navy, Medical Department GO66/K, Empress State Building, London, S.W.6.

"electives" at other hospitals or working with general practitioners. Comparatively little time is devoted to lectures, most of the teaching being done in small groups and seminars. A year of internship is followed by two and a half years of compulsory military service and one year of rural service.

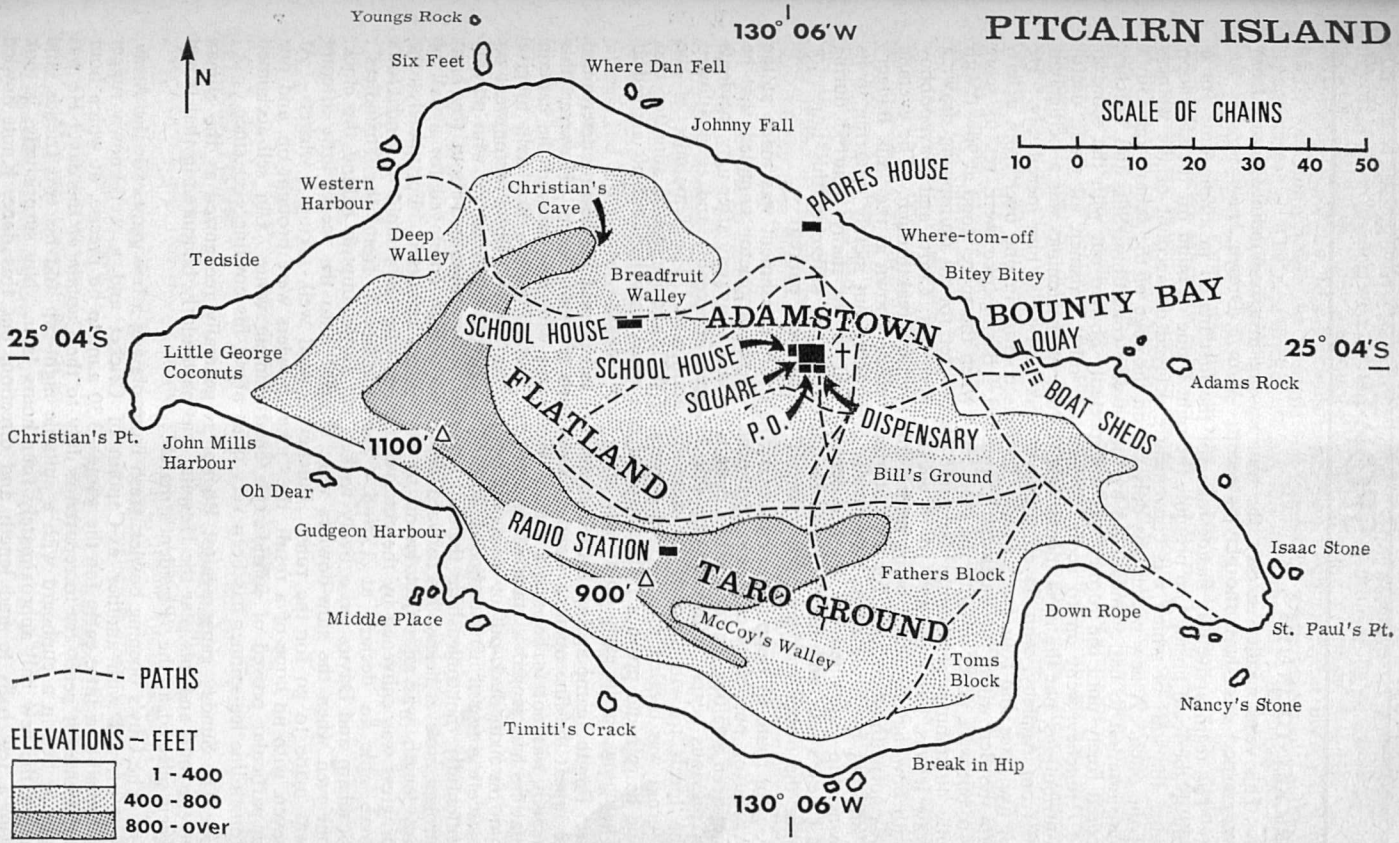
When the State was established the level of health was by no means low. Malaria had been almost eradicated and the infant mortality was not much below accepted standards. But in 1948 came many immigrants from under-developed countries suffering from illnesses which were under control in Israel and which could easily have produced epidemics. The Yemenites brought bilharzia, trachoma and tuberculosis. A group from Cochin, India, brought victims of Filariasis easily transmitted by the common Culex mosquito. From North Africa came tens of thousands with ringworm, schistosomiasis, blindness and malnutrition. Another problem was concerned with the economic absorption of these people, most of whom arrived with no means of their own. It took until 1954 to cope with these difficulties and since then the health of the country has been established. About eighty per cent of the population benefit from medical insurance schemes which are calculated according to the wage earner's salary, and thus medical care is available to all. Recently, the newly developing African States have shown much interest in the way the Israelis tackled basic health and epidemiological problems during the past fifty years, and it is hoped that her experiences may be of some value to them.

The many ethnic groups which populate Israel makes the country an ideal field for comparative medical studies; as between the Oriental Jews and Bedouin Arabs on the one hand who seem freer of such diseases as atherosclerosis and diabetes, than the Jew from the Western lands. The fact that Israeli citizens hail from a hundred different countries offers the doctor a fascinating variety of human and medical problems, and the Hadassah Hospital has now become a meeting place for scientists from all over the world, and a focus of post-graduate study.

"Only when scholars from abroad find it worth their while to come to us as guests, to gather first-hand information about the results of our research work, only then shall we have won equality as scientists and the opportunity to repay what we, as wandering Jews, have learnt in the different universities of the world." Chaim Weitzmann, First President of the State.

Guy's Hospital Music Club
Christmas Concert, 1965

The Music Club will be singing the annual Christmas Concert in Southwark Cathedral on 14th December. Robert Sells will conduct the chorus and orchestra in Kodaly's Missa Brevis and Bach's Magnificat in D. Both works contain exciting chorus passages, and practice for the chorus will begin on Monday, 6th September, at 5.15 p.m. in the East Wing. Everyone connected with Guy's who wishes to sing will be very welcome.



This map was omitted from the article "A Visit to Pitcairn Island", by Michael D. Steyn. Our thanks are due to Miss G. Sanders, of the Department of Medical Illustration, who so expertly reproduced the original sketch.

SPORT

CRICKET TOUR - 1965

This year, needless to say, the tour was again a resounding success from every aspect—not least the playing record—Won 2, Drawn 2.

The team arrived at Basingstoke for the first match in ample time for a visit to the local hostelry to promote the right frame of mind for the afternoon game, the start of which was conveniently delayed on account of the wetness of the pitch. A new wicket was duly cut on the edge of the square and Guy's were inserted to bat. Undaunted by the adverse conditions, Silk and Butchey scored freely until the former was unexpectedly bowled out with the score at 44. Butchey went on to score 52 and the other batsmen all made useful contributions, but the most memorable feature of the innings was a belligerent 56 from Appleby, who flayed whatever was bowled at him mercilessly. He hit five sixes and four fours in all—23 runs coming in one over from a left-arm bowler whom he particularly relished. Basingstoke were set to score 210, but were never up with the clock, and when the score stood at 90—1 with only 40 minutes remaining, the game looked set for an uninspiring draw; a draw it was, but only just, for 8 wickets were lost, Crafts and Davoodbhoy both bowling off-breaks, being responsible for the breakthrough. The evening was not without incident for the notorious vehicle known as the "Silk Banger" —silk not by virtue of its smoothness of running but merely referring to its ownership—sustained yet another dent to add to the many incurred during last year's tour and since. However, there was one difference this time—for once the owner was not at the wheel; the car was parked!

En route to Bognor the customary halt for refreshment was made at the White (or possibly Red) Lion, Selborne, whose proprietor confided that he had been awaiting that day with a certain amount of anxiety after ugly incidents in previous years. However, the side behaved impeccably and even allowed the locals to win at darts to avert any animosity! The remainder of the journey was tackled with varying degrees of skill, and it must be admitted that one hairpin did prove a little sharp for one weary traveller, but all arrived at Thatchings in the early hours safe and thirsty again!

For the game against Littlehampton the tail opened the batting determined to repeat the fine opening stand of last year's ten and eleven. However, this year it was not to be, and a certain Welshman who had assured the captain that he had scored a stack of runs for the 2nd XI took a first ball, to give him his sixth duck out of seven innings for the 1st XI. But Proctor went on to score a useful, if unorthodox, 25, ably supported by Beacham who playing watchfully, not unleashing the full array of his much-talked-about (by him) strokes. Nevertheless, his forward defensive, though employed for a ball of any length, was an object lesson to any young cricketer. Fortunately, the progress was enlivened by the entry of Cutler, who hit a rapid 41, and Guy's were able to declare at 157—8. Accurate spells from the "trundlers", Beacham and Davies on a lively wicket, put Littlehampton behind the clock, but even when the slow-bowlers were brought onto the scene, little attempt was made to go for the runs. Butchey bowled well, taking 4 wickets. At seven, with no hope of a result, the "joke" bowlers were brought on, and one in particular proved of considerable entertainment value. Our self-acclaimed fourth-line leg-spinner has been very quiet about his bowling ever since.

The Sunday game against Bognor is generally recognized as the climax to the tour, and this year the Hospital was particularly honoured in that it had been selected as the "President's match".

The Guy's opening bowler, fresh from playing a few games for the Army, had arrived with another ex-Captain of Cricket and a well-known rugger personality a little early for the game—3.30 a.m. to be precise, at which hour he deemed it necessary to report for duty to the Captain of the day. He was put to bed in a cupboard with a suitable night-cap and his two friends, and given the new ball approximately four hours later. Not surprisingly, it took him a few balls to find length and direction, but this done, Knott bowled

excellently, taking 3 wickets before lunch. With Beacham taking another at the other end, Bognor were in the unenviable position of being 63—4 at the interval. However, they were unperturbed, for the President had laid on a magnificent luncheon, together with more than a sufficiency of beer and wine which was pumped into the bowlers, and indeed the whole team, with enthusiastic generosity. The next wicket did not fall until the score had reached 121. When the effects of the lunch had worn off a few more wickets were captured, but Bognor were able to declare at 198—9. In reply, Guy's progressed steadily but when Cutler was out, having scored a sparkling 62 in 68 minutes, the game looked delicately balanced with the score at 120—5. The periodic fall of wickets swung the odds in Bognor's favour, but a defiant undefeated 64 by Powell-Jackson gave the Hospital victory with the last man at the wicket and only five minutes to spare—a breathtaking finish to a fine game of cricket. Having steered the side to victory in his best innings of the season in which he displayed a wide range of strokes, Powell-Jackson put up his best performance in the bar by drinking a wide range of drinks, against strong competition from the old "worthies" who had travelled down from London Bridge for the day to give much welcome support.

The next day to the relief of some, but the disappointment of most, the match against Ferring was washed out, and the hours were whiled away playing spoof in the Ship for G.B.L's. and cards out of licensing hours.

Tuesday and Wednesday, the official rest days, were occupied with a variety of pursuits in fine sun. Most seemed eager to demonstrate their prowess on the links—although after the round several looked somewhat crest-fallen. One "professional" was heard to announce that but for the fact that he had lost ten golf balls he had had a good round!

The full Selsey Run was completed by five members, two of whom have since repented by turning tea-total. The exact time taken was not recorded since by the time they had finished they had no recollection of when they had started.

For the match against Cuckfield, on the journey home, tradition was ignored and Guy's were callously asked to field—a cruel blow to the side. As a result of these underhand tactics, Cuckfield had scored 130—1 by lunch. However, after the interval, with some food inside them, Appleby and Crafts restored the equilibrium somewhat by bowling the rest of the side out for only a further 82. Set to score 212, McGregor received his usual "unplayable" second ball of the innings, and Silk followed him not very long after. This brought Powell-Jackson and Griffiths together, and these two improved the position with a 65 run partnership, but the partnership of the match was the century stand between Griffiths, who batted delightfully to score 75, and the big-hitting Appleby, who hit two sixes in his 57. Unfortunately, they were both out with victory only 27 runs away, and with two more wickets tumbling in quick succession and time running out, it began to look as if their efforts might have been wasted. But the Captain came in and in uncharacteristic fashion hit 12 off an over to settle the issue and give Guy's a fine victory. The team's elation was expressed in joyous songs in the bar afterwards lead by the notorious Dr. Reekie who had come down, it is thought, solely for this purpose.

A fitting end to another most enjoyable tour.

REPORTS AND RESULTS

CRICKET TOUR

GUY'S v. BASINGSTOKE. 30th July.
Guy's, 209—6 dec. (Appleby, 56; Butchey, 52; Crafts, 27 n.o.)
Basingstoke, 126—8. (Crafts, 4—26; Davoodbhoy, 3—51.)
Match Drawn

GUY'S v. LITTLEHAMPTON.
Guy's, 157—8 dec. (Cutler, 41; Silk, 26 n.o.; Proctor, 25.)
Littlehampton, 113—6. (Butchey, 4—27.)
Match Drawn

GUY'S v. BOGNOR.
Bognor, 198—9 dec. (Knott, 3—62; Davoodbhoy, 3—66.)
Guy's, 199—9. (Powell-Jackson, 64 n.o.; Cutler, 62.)
Guy's won by 1 wicket

GUY'S v. CUCKFIELD.
Cuckfield, 212. (Appleby, 5—60; Crafts, 3—19.)
Guy's, 215—7. (Griffiths, 75; Appleby, 57; Powell-Jackson, 30.)
Guy's won by 3 wickets

National Provincial

The Guy's Hospital Office, which is opened for your especial use, is under the management of Mr. A. C. Edwards, Southwark Branch, 12-14, Southwark Street, London, S.E.1, and enquiries will be welcomed.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL AND SOUTH-EAST METROPOLITAN REGIONAL HOSPITAL BOARD.

Applications are invited for the post of **Senior Registrar in Orthodontics.** The duties are to be shared between these bodies as follows: Guy's Hospital, six sessions, and the *South-East Metropolitan Regional Hospital* Board, five sessions, with attachment to the Woolwich Group and the neighbouring Groups in S.E. London. Details regarding the post and forms of application, which should be lodged not later than **Saturday, 18th September, 1965,** are obtainable from the Superintendent, Guy's Hospital, London, S.E.1.

THE ROYAL MARSDEN HOSPITAL, SURREY BRANCH, DOWNS ROAD, SUTTON, SURREY.

Applications are invited for the post of **Resident House Officer (Radiotherapy) with Surgical Duties.** Senior House Officer Grade. This is a Post-graduate Teaching Hospital—a Radiotherapy Centre with high energy apparatus and 99 beds. The appointment will be for one year. Application forms can be obtained from the Administrator, to whom they should be returned as soon as possible.

GREENWICH DISTRICT HOSPITAL, Miller General Wing, Greenwich High Road, S.E.10. (189 beds). Recognised for F.R.C.S. Examination. HOUSE SURGEON vacant 21st September. Six months appointment. National salary and conditions. Write with testimonials/references to Group Secretary, G. & D. H.M.C. Greenwich District Hospital, St. Alfege's Wing, Vanbrugh Hill, S.E.10.

PASS LISTS

ROYAL COLLEGE OF SURGEONS OF ENGLAND
F.R.C.S.

J. K. Duff

ROYAL COLLEGE OF PHYSICIANS OF LONDON
M.R.C.P.

I. D. Green
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A. S. Russell
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M.R.C.P.

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J. W. Heber
P. J. Snow
J. C. Simpson

D.P.M.

G. D. Banyard
J. E. Oliver
W. E. M. Pryse-Phillips
G. E. Thomas

SOCIETY OF APOTHECARIES OF LONDON
Final Examination

Surgery

N. W. D. Walshaw

Medicine

M. A. Q. Jamil

Midwifery

M. J. Elliott

UNIVERSITY OF LONDON
B.Sc. Special Examination
Anatomy (Second Class Honours)

I. A. Baker

1st Examination for Medical Degrees

P. A. Breen

The following have been exempted:

O. A. Adesina
D. N. Anderson
Marion J. Apthorp
R. G. A. Behrman
G. P. Booth
R. A. Burlinson
J. S. Cunliffe
Carina Dovey
Hilary C. Hodge
Sally E. Hunter
D. Jackson
R. W. Jones
L. Z. Klich
R. A. Lomax
I. J. Mackenzie
K. W. Malia
R. Manna
J. M. Morsman
P. L. Neustatter
C. G. Neville
M. J. Nockles
J. A. Osborne
J. R. M. Ross
E. D. Scarlatos
K. J. B. Sommi
D. H. H. Steer
W. H. Stephens
Tang Meng Kuan
Clare C. Walters
T. H. Watford
Deborah M. Wiggins
P. R. Wright

UNIVERSITY OF LONDON
RECOGNITION OF TEACHERS

A. J. Bridge as teacher of Dental Surgery.
M. N. Naylor as teacher of Preventive Dentistry.
C. W. T. Shuttleworth as teacher of Dental Bacteriology.
A. R. Ten Cate as teacher of Dental Anatomy.

Dr. W. Fox has been appointed Director of the Tuberculosis and Chest Diseases Research Unit, Medical Research Council.

Professor W. J. H. Butterfield has been appointed Oliver-Sharpey Lecturer of the Royal College of Physicians for 1966.

HOUSE APPOINTMENTS

GUY'S HOSPITAL
1st September, 1965

Assistant House Surgeons

To:

Mr. Lawrie — Mr. D. R. Bevan
Appointed for 6 *months, the first* 3 *as A.H.S.*
Mr. Glover — Mr. A. R. M. Upton
Appointed for 6 *months, the first* 3 *as A.H.S.*
Mr. Brain — Mr. G. A. Pettitt
Appointed for 6 *months, the first* 3 *as A.H.S.*
Mr. Beard — Miss J. A. Chown
3 *months*

Assistant House Physicians

To:

Dr. Mann, Dr. Scott and Dr. Bishop — Mr. T. J. R. Bruce
Appointed for 6 *months, the first* 3 *as A.H.P.*
Dr. Hardwick, Dr. Trounce and Dr. Deuchar — Mr. A. M. Morris
Appointed for 6 *months, the first* 3 *as A.H.P.*

Dr. Baker, Dr. Houston and Dr. Grimble — Mr. N. W. D. Walshaw
Appointed for 6 months, the first 3 as A.H.P.

Dr. Kauntze and Dr. Joiner — Miss E. A. Cosgrove
Appointed for 6 months, the first 3 as A.H.P.

Professor Butterfield and Dr. MacLean — Mr. A. M. Roberts
3 *months*

Casualty Officers
Mr. M. B. Barnett — Mr. B. H. Hicks
Mr. P. D. Davies — Miss C. J. S. Lawrie
Mr. C. G. C. Gaches — Miss J. P. Pearse

House Surgeon to the Surgical Unit
Mr. M. L. Wastie
3 *months*

House Surgeons
To:
Mr. Eckhoff — Mr. H. D. Tunstall-Pedoe
3 *months*
Professor Atkins — Mr. T. M. Jenkinson
6 *months*
Mr. Wass — Miss C. G. E. Gladstone
3 *months*
Mr. Blackburn — Mr. M. W. J. Older
6 *months*

House Physicians
To:
Dr. Mann, Dr. Scott and Dr. Bishop — Mr. R. Gilkes
3 *months*
Dr. Hardwick, Dr. Trounce and Dr. Deuchar — Mr. A. J. Knell
3 *months*
Dr. Baker, Dr. Houston and Dr. Grimble — Mr. A. L. W. F. Eddleston
6 *months*
Dr. Kauntze and Dr. Joiner — Mr. R. A. Y. Pietroni
6 *months*
Professor Butterfield and Dr. MacLean — Mr. T. C. Davis
3 *months*

Resident Obstetricians
Mr. R. G. Pirritt — 3 *months*
Mr. D. J. Simler — 6 *months*

Gynaecological House Surgeon
Mr. J. B. M. Shepherd — 6 *months*

Throat and Ear House Surgeons
Mr. J. M. I. Iveson — 3 *months*
Mr. C. R. Sheard — 6 *months*

Orthopaedic House Surgeons
Mr. G. F. Falconer — Mr. I. C. M. MacLennan
3 *months*

Dermatological House Physician
1.8.65—31.1.66 — Miss E. Sherbel

Neurological House Physician
Mr. C. W. P. Warren — 6 *months*

Genito-Urinary House Surgeon
Mr. P. A. Kitchener — 3 *months*

House Surgeons to the Thoracic Unit
Mr. R. J. Parker (S.H.O.) — 6 *months*
Mr. J. G. Cochrane — 3 *months*

Children's House Physicians
Miss S. A. Marshall — 3 *months*
Mr. G. Hambleton — 6 *months*

House Physicians in Clinical Pathology
Mr. M. D. Jones — 3 *months*
Mr. J. Burke — 6 *months*

House Physician to Dr. Bishop, Dr. Wayte and Mr. McArthur
Mr. G. Llewellin — 6 *months*

House Physicians in the Department of Psychological Medicine
1. 4.65—30. 9.65 — Miss M. Restell
1. 4.65—30. 9.65 — Mr. R. H. S. Mindham
1.10.65—31. 3.66 — Mr. P. Nott
1.10.65—31. 3.66 — Mr. K. F. Standage

R.M.Os. in Nuffield House
1. 7.65—31.12.65 — Mr. C. S. Good
1. 9.65—28. 2.66 — Readvertised

Resident Anaesthetists
1. 6.65—30.11.65 — Mr. M. J. Wright (S.H.O.)
1. 6.65—30.11.65 — Mr. D. E. Nancekievill
1. 9.65—28. 2.66 — Mr. R. K. R. Innes (S.H.O.)
1. 9.65—28. 2.66 — Mr. T. E. J. Healy

HITHER GREEN HOSPITAL
House Physician in General Medicine and Infectious Diseases (from 1.10.65): Mr. D. J. O'Gorman

JOYCE GREEN HOSPITAL
House Surgeon (from 23.8.65): Readvertised
House Surgeon (from 25.9.65): Readvertised

LEWISHAM HOSPITAL
House Physician to Dr. Llewellyn Smith: Mr. I. Reekie
House Surgeon to Mr. Cavendish (from 5.9.65): Readvertised

NEW CROSS HOSPITAL
House Physician in Medicine and Geriatrics S.H.O.: Mr. A. Thomas
House Physician in Medicine and Geriatrics: Mr. H. Munitz

ORPINGTON HOSPITAL
House Physician: Readvertised
House Surgeon (from 1.10.65): Mr. J. K. Beattie

QUEEN MARY'S HOSPITAL, SIDCUP
House Physician: Readvertised
J. B. BLAIKLEY, Superintendent.

NURSING NEWS

Entered:
Sister Barnes as Relief Assistant Matron.
Sister J. Courtney to Nuffield House.
Left:
Sister B. Ford from Christopher.

BIRTHS

HOLDEN.—On 12th June, 1965, to Barbara and Geoffrey Holden, of 9, Stanstead Close, Hayesford Park, Bromley, Kent, a daughter, Zena Clare, a sister for Rosemary and Andrew.

OWEN.—To Marion (née Oates) and Roger Owen, of Whitechurch, Aylesbury, a son, Lance Edward.

CHANGE OF ADDRESS

Dr. and Mrs. Anthony Trafford, to Tarnova, 14, The Upper Drive, Hove 3, Sussex. Telephone No.; Brighton 31567.

GUY'S HOSPITAL GAZETTE

FORTNIGHTLY TWO SHILLINGS VOLUME 79 NUMBER 2012

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EDITORS P. BOWDEN AND A. E. RAYNES

SPORTS CORRESPONDENT A. PROCTER

GUY'S HOSPITAL, LONDON

PASSIM

In Days of Old

The Book of Health, Compendium of Domestic Medicine, deduced from the experience of the most eminent modern practitioners, was first published in 1828. The book opens with a dictum stating that "errors in diet are the great source of disease ; medicine may relieve or suspend, but can never cure without the aid of regimen." " I say it is horribly absurd, and I have no patience to hear and see what I do, as if medicine could cure a disease." Thus spoke Mr. Abernethy who, together with C. T. Thackrash, Esq., Surgeon, Dr. Armstrong, Dr. Clutterbuck and a Sir Astley Cooper, represented, as far as the Book of Health was concerned, the authority of Medicine of their era.

Astley Cooper emerges as an ardent protagonist of the lancet, and is quoted thus "In our endeavours to reduce inflammation, we shall rarely find local means sufficient. Our chief means are constitutional and the first of these is blood letting. It is necessary, in employing the lancet, to make a large orifice in the blood vessel selected for the operation, as the effect depends on the quickness with which the blood is drawn away." Neither did Mr. Abernethy mince his words on this subject: " I will rather be the executioner myself, than suffer the disease to kill the patient."

They were truly grim days. " Cobwebs, spiders, etc., are sometimes recommended for ague; but their nastiness is sufficient to set them aside. However, a modern writer (1827) recommends ten grains of cobweb to be taken twice or thrice before the expected time of each fit." Sir Astley Cooper's " Lectures on Surgery " is freely quoted throughout, and the excerpts are authoritative and dogmatic: " Cancer on the lip arises from the use of the pipe . . . for I never saw it on the upper lip but once. An operation for the complete removal of the disease is the patient's only real hope of succour", for carbuncle, " A little wine or good porter is recommended," catheterisation for " inflammation of the bladder" and for " dropsy of the belly", calomel and squills. " If I were asked", Cooper is quoted as saying, " the cause of stricture, I should say, in 99 cases out of 100, it is the result of gonorrhoea", but Abernethy differed, " drinking and hard riding are the cause." The latter continues to say: " I'll be hanged if erysipelas (St. Anthony's Fire) is not always the result of a disordered state of the digestive organs."

Attention has been diverted from the imagined idiosyncrasies of the gastro-intestinal tract and the error of public pronouncement has been replaced by saying nothing with verbosity. But medicine was a different matter in those days, "It has been pretty accurately calculated that the victims to this disease (Pulmonary Consumption) in Great Britain, exceed fifty-five thousand annually; and one-fourth of the inhabitants of Europe."

New Bleeps for Old

At a cost of five thousand six hundred pounds, the hospital is having a new bleep system installed by Cass Electronics. The old system has been in operation for seven years and its ageing unreliability has made its end inevitable.

The advantage of the new system is its flexibility. When it comes into operation on September 1st it will supply 120 bleeps with a potential of increasing to 500, and it will be possible to send out two different bleeps at the same time, which can be increased to four. The central exchange will be moved to the hospital main switch board which has a relatively unlimited number of lines, so that the exchange will always be obtainable and blockage will be virtually eliminated.

One apparent disadvantage of the new system is that the bleeps themselves are run by accumulators and will have to be charged regularly. This will necessitate the bleep being left in a charging panel in the East Wing for about three or four hours every day, but while there its location will be automatically registered at the central switch board. However, unless the houseman or student is in some way physically attached to the bleep, his whereabouts will be unknown, a situation which rarely arose under the personal service of the operators in the East Wing. The Cass system also has the potential for two-way talking through the bleeps, but this is not likely to be exploited in the near future. Unlike the speaker system on the theatre floor, housemen will not be summoned by an omnipotent formless voice and be compelled to drop everything and run.

Salomons Welfare Centre

In this issue Miss Saint describes the work done in Salomon's Welfare Centre. It was one of Dr. H. C. Cameron's ideas; it opened in 1920, one of the first child welfare centres in the country. For 25 years it was a flourishing training school for health visitors with the latter and students living-in. Cameron saw the centre as essentially part of the hospital and its services for the Borough children. Perhaps the paediatricians may take a lesson from the obstetricians who have always carried out their ante-natal clinics in the Centre, for they see the preventive part of their work as part of their hospital duties rather than as something to be done under an outside agency.

GUY'S DIARY

SEPTEMBER

Exhibition.		*Head Injuries.*
11th S.	10.00	Departmental Round will be conducted in the Clinical theatre.
16th Th.	5.00	Neurosurgical Round will be conducted in the Clinical theatre by Mr. MURRAY FALCONER.

THE WORK OF THE CHILD WELFARE CLINICS

Miss G. Saint, S.R.N., H.V.,
Superintendent Health Visitor,
Salomons Centre, Guy's Hospital

The work of the child welfare clinic is as demanding, satisfying and exciting as that of the curative medicine practised in hospitals and general practice, but the problems to be solved and the attitudes and knowledge required by those who work in these clinics is very different.

The National Health Service Act, 1946, Part 3, Section 24 (1) broadly states:—

"It is the duty of all local health authorities to make provisions in their areas for the care of mothers and young children."

Child Welfare Clinics, usually combined and under one roof with a maternity clinic, are one of the services the local health authority provides to fulfil this duty.

Originally the work of the child welfare clinic was life saving by means of education to combat the gross ignorance of hygiene and infant feeding. To this was added periodic examination of infants and children under school age to detect physical illness.

Because of the prevalence of malnutrition and poverty, the distribution of free or cheaper welfare foods became an important part of the work. From the 1930's immunisations were added. With improved economic conditions and general knowledge of child care, the health education was able to take a more positive slant. The National Health Service gave every child two doctors with statutory responsibilities towards him or her, the family doctor and the medical officer of health through the welfare clinic doctor who works with the health visitors.

Since the early days of the child welfare clinics the lives and needs of the people they serve have changed enormously and the work of the clinics is now undergoing a general reappraisal.

THE AIMS OF THE WORK OF THE CHILD WELFARE CLINICS TODAY

To-day the child welfare clinic is recognised as the place where preventive and supportive medical services can readily be obtained. Its new aims are

Preventive mental health by informing and advising mothers and by recognising where special guidance and help is needed to promote the mental health of children.

Prevention of break-up of families. While the children's departments of local authorities have power to take action to avoid the need for children to be taken into care, the child welfare services have the great advantage of being in a position to recognise much earlier the signs of stress that could lead to break up. The welfare clinic staff can take preventive action at an earlier stage. They have contacts and exchange information with various medical and social agencies. They give support to families by deployment of home helps, day nurseries, child minders, part-time creches, and where necessary can mobilise medical and psychiatric help.

Early diagnosis of congenital handicaps. Infants are routinely screened for phenyl-ketonuria. Developmental examinations which will detect development delay at an early stage and screening techniques for early detection of hearing loss or defects of vision are increasingly widely carried out by clinic doctors. Infants whose pregnancy, birth or neonatal history suggests they are especially "at risk" of sensory, motor or intellectual handicaps are the subjects of specially close follow-up.

Health Education. Public Health Staffs have always played a leading role in the promotion of health and the prevention of disease, and the National Health Service lays special responsibility for health education on the local authority medical service. The Welfare Services will shortly have an important task in educating women to have periodic examinations for exclusion or recognition of cervical cancer, just as they have had to "sell" immunisations for babies and children. There is a greater appreciation of economic and social factors in the origins of physical and mental ill-health and a desire to do something more in the way of prevention.

The promotion and maintenance of positive health to a large extent depends on good physical and social environment. The welfare clinics' aim is to educate and help the members of the community, to make their individual contributions. The attainments of good environmental conditions is somewhat marred by the inadequate and defective housing provisions which are one of the largest and most depressing problems in public health work.

The techniques of health education include talks to individuals, informal group discussions, films, demonstrations, posters, pamphlets, etc.

Immunisations.

The prevention of diphtheria, pertussis, tetanus, poliomyelitis and smallpox is largely achieved, but constant effort is required to keep a high rate in communities which have not known these illnesses as killing or crippling. Vaccination against measles is on the way and B.C.G. is given to infants and children at risk.

Early recognition of illness.

The welfare clinic often has the advantage that the mother feels she can go there when she is not sure whether there is anything wrong. She often regards her general practitioner as a busy person to whom she goes when she is certain that the child has a "real" illness. The Welfare Clinic doctor may explain and advise, but he does not give medicines. For treatment he refers the mother and child to her family doctor.

WHAT DOES THE MOTHER GET FROM THE CHILD WELFARE CLINIC ?

Before she attended her ante-natal clinic the mother will have associated nurses and doctors with illness; there she learns to associate them with the maintenance of health. The atmosphere should be as informal and friendly as possible to encourage this change of attitude and to make the mother receptive to explanation and education. The mother usually makes her first contact with the health visitor at the ante-natal clinic, where she and her husband will be invited to attend the health visitors' mothercraft and parentcraft classes and come to realize where she can turn for help and guidance. After her child is born what does she get from the child welfare clinic?

Infant management.

Many mothers with new babies have no memories of seeing their own mothers care for their younger brothers and sisters. Their own parents may not be available to help. The health visitor's advice may make life much easier for an inexperienced mother and make the mother's acceptance for her baby a quicker and happier transition.

Social Contact.

To-day young couples establish their homes wherever they can find housing. They are not always near the relatives who, in the past, were the main source of company and support to young parents. With this break-up of close family groups, clinics often provide a useful social contact for the young mother new to a neighbourhood.

In the special case of a mother with a handicapped child, her "own" clinic and health visitor are often chosen by her as her main source of support, although she may attend a special local authority or hospital clinic. The acceptance of the handicapped child by those she meets at the clinic helps the mother to accept the child and is a step towards the acceptance of the child by the community.

Health Education.

There is more in health education than teaching the technology of child care. Health is more than the absence of disease and planning ahead is necessary if the best level of health is to be attained by the child. The mother learns what health is and how she can work to achieve it for her child.

Health supervision and immunisations.

The mother's visits for her child's periodic health examinations give her an opportunity to get answers to her various questions and the clinic staff an opportunity for explanation and advice. When a mother is reluctant or doubtful about periodic checks, the health visitor can explain and encourage.

Mothers can ask about immunisations; they are encouraged to understand and agree to the procedures recommended.

Developmental Examinations and screening tests.

From the developmental examinations, as from the physical checks, the mother learns something of the range of normal and may thereby lose unnecessary fears. She will be glad to have the normality of her child's hearing and vision demonstrated.

Where these deviations from the normal and where definite defect is found, the mother will be referred via her general practitioner to the appropriate specialist or paediatric department.

Family Problems.

The mother who is more or less near breaking point because of economic or marital problems or from simple overwork finds help in the friendship of the health visitor. She has someone to turn to in her repeated crises and someone who accepts her and visits and helps her in her home, by listening and suggesting, by obtaining a home help or getting an older child into a day nursery.

The staff of the clinic accept the mother who is incompetent, for they know the heavy odds which weigh against a mother of poor physical and mental gifts struggling in circumstances which them-

selves hamper her efforts. They also know that belief in personal responsibility must not stop them from giving help to a mother if she needs it, and can never be applied to the children however inadequate and feckless the parents.

THE HEALTH VISITOR

The health visitor visits. She meets families in their homes and comes to know them and be known to them. When she visits mothers with new babies after the midwife has completed her duties, she makes a point of inviting them to the local child welfare clinic which she organises. Attendance is not compulsory, so in some cases it may be necessary for the health visitor to educate in the home as well as using persuasive techniques to encourage inexperienced apprehensive mothers and those in need of it, to use the service.

As a state registered nurse and as a midwife (at least Part I) she has a background of medical knowledge; her training for her health visitor's certificate gives her a knowledge of social case work, aspects of development health, health legislation and various teaching techniques. She should possess the foresight and ability to assess and select features in the circumstances of certain families which indicate a remedy is needed. Particular problems may be referred by her to other specialist statutory or voluntary agencies. She supports the persistently inadequate families which need to be tolerated and helped.

"The child welfare clinic should be the health visitor's base, office and consulting room. She should not just act as a chaperon or surgery-nurse, these are the duties of ancillary workers." (Health Visitor's Inquiry, 1953.)

Mothers expect her to be a willing sympathetic listener and guide at the consultations in the clinic which complement her home visits. She is privileged in knowing the families in her district and the children from before their birth until they are five, and sometimes until they reach school-leaving age, at all times and not just at times of stress.

It is essential for time to be given for discussion between health visitors and doctor so that the child, parent or family may benefit from a combined and unified approach to particular problems of child or family care. Teamwork is of vital importance in the clinic.

Experienced clinic doctors and health visitors not infrequently hear tearful, inexperienced mothers complain of the conflicting advice and views they receive not only from well meaning friends and relatives, but also from various members of the hospital staff or their team of general practitioners. "If these people, whose job it is to know about these things, cannot tell me what to do, what should I do? Why do they talk to me as if I am a moron?" they cry. This is usually not an effort on the mother's part to play off one professional person against another, but a desperate plea for a simple, clear answer. This we know is not always possible, but unfortunately, all too often a variety of dogmatic orders have been given which have

left the mother bewildered and confused. Patient explanation of underlying reasons would have helped her understand and so to accept the advice given and to come to act wisely on her own on a future occasion.

THE CHILD WELFARE DOCTOR

The doctor who works in a child welfare clinic needs a very different set of attitudes, knowledge and skills from those he finds most useful in dealing with patients in a surgery or in a hospital. His work in the clinic is of two sorts. He does health education and preventive work with mothers and children and he deals with vulnerable and problem families striving to keep the families going and to ensure a fairer chance for the children.

In his educational and preventive work with mothers and children, he needs to take pleasure in seeing physical and mental health. He will be interested and knowledgeable about growth and development. He will, from this interest, learn the range of normal health and development. He will learn to detect deviations from the average and to assess the degree of deviation and to recognise when it requires further investigation. He will learn to do developmental assessments and screening tests of hearing and vision. He may have to be prepared to help handicapped children and their mothers so that no secondary handicaps develop.

In collaboration with the health visitors, he will meet and deal with the needs of vulnerable and problem families. He learns to help them and to accept them, and to forget to criticize them. Their needs spring from physical, intellectual, emotional and social defects. He has to see where he can help and to recognise good qualities that can be built up.

In addition the child welfare clinic doctor can be a valuable liaison between the local authority, general practice and hospital medical services, linking the three branches of the tripartite Health Service.

If the Welfare clinic doctor is to do his job competently, he will need postgraduate training for this work, for the paediatric training of most doctors is largely in diagnosis and treatment of illness. If he has not been taught the aims of his work in the clinic, he may go there, find no illness and say " there was nothing for me to do."

The postgraduate training for this work must include learning about

The aims of the child welfare services.
Physical, intellectual and emotional development.
Developmental assessment techniques.
Screening tests of hearing and vision in young children.
Health education.
Helping vulnerable and problem families.
Social and other services available in the area.

EARLY RECOGNITION OF HANDICAPS

Child welfare clinics can make a great contribution to improved care of handicapped children. The earlier that handicaps such as

deafness, defective vision, cerebral palsy are detected, the earlier treatment can be given and the less disabling the handicap will be. Handicaps are commoner in children who have a family history of congenital deafness or blindness, or who have suffered certain stresses during development.

Examples are rubella during the first 16 weeks of foetal life, foetal distress during labour, or severe jaundice in the neonatal period.

From their family history and history of pregnancy, and perinatal period, certain infants can be identified as being "at risk." It can be shown that 70 or 80 per cent. of handicaps occur in a group of 20 per cent. of infants selected by certain criteria as being at risk. Howarth in 1958 found an incidence of deafness of 0.65 per 1,000 in 3,065 children not "at risk", and 9.06 per 1,000 among 662 "at risk" children. Gardiner has shown the same for visual defects and Illingworth for cerebral palsy.

It will be an economy of effort to give special attention to one fifth of all infants picked out as being at risk.

Factors indicating that an infant may be at risk include the following, especially if more than one is present.

GENETIC.

Family history of congenital deafness or blindness.

PRENATAL.

Rubella in first 16 weeks.
Bleeding in early months.
Severe illness or major surgery in early months.
Thyrotoxicosis in mother.
Diabetes mellitus.

PERINATAL.

Gestation under 36 weeks.
Gestation over 42 weeks.
Foetal distress.
Birth weight under 4lbs.
Prolonged failure to start breathing.

POSTNATAL.

Prolonged poor sucking.
Cyanotic attacks.
Convulsions.
Apathy.
Hyperexcitability.
Severe jaundice.
Congenital abnormalities.

The selection of infants for the at risk register must be such that it includes about 15 or 20 per cent. of children.

The records of such infants must be distinguishable. They are followed at 3-monthly intervals till the age of 2 years.

If a defect is discovered, treatment is obtained and the infant or child placed on the register of handicapped children to ensure specialist care and suitable educational provision.

ORGANISATION

The staff at the child welfare clinic are often those the mother has come to know at the ante-natal clinic. In addition to the health visitors and the clinic doctor, there is an ancilliary staff which may include:—Clinic nurse, welfare foods sales clerk, pram assistant and clerical assistant. Some of these duties may be undertaken by voluntary helpers especially in the toddler's playroom or canteen.

The clinic must be on the ground floor. A covered pram park should be situated near the entrance. The entrance waiting room should be designed to display topical health education posters, pamphlet rack, display showcase and any electrical teaching aids. The toddlers' playroom with a capable person in charge is an asset. With a one-way vision glass screen a mother can observe and discuss her child's behaviour with the health visitor and be greatly helped. Three smaller rooms should be used as a feeding room, general purpose room and isolation room. It is also desirable to provide one or two small rooms where privacy is ensured for taking histories and confidential consultations. Records should be comprehensive, containing only essential and relevant information. They are passed on to the School Medical Service when the child reaches school age.

Very few mothers never attend child welfare clinics; a few may attend once. The general tendency is for the majority of mothers with first babies to attend their clinics at one, two or three weekly intervals until the baby reaches about six months, when they usually consider his feeding and growth are progressing satisfactorily. Then attendances are reduced to about monthly visits until the baby is about one year when they begin to express themselves in ways more acceptable to the parents and fit more easily into the family pattern; then the parents feel more independent and self-reliant, not so much in need of the support and reassurance of the clinic. Thereafter their attendances decline. But not in all cases.

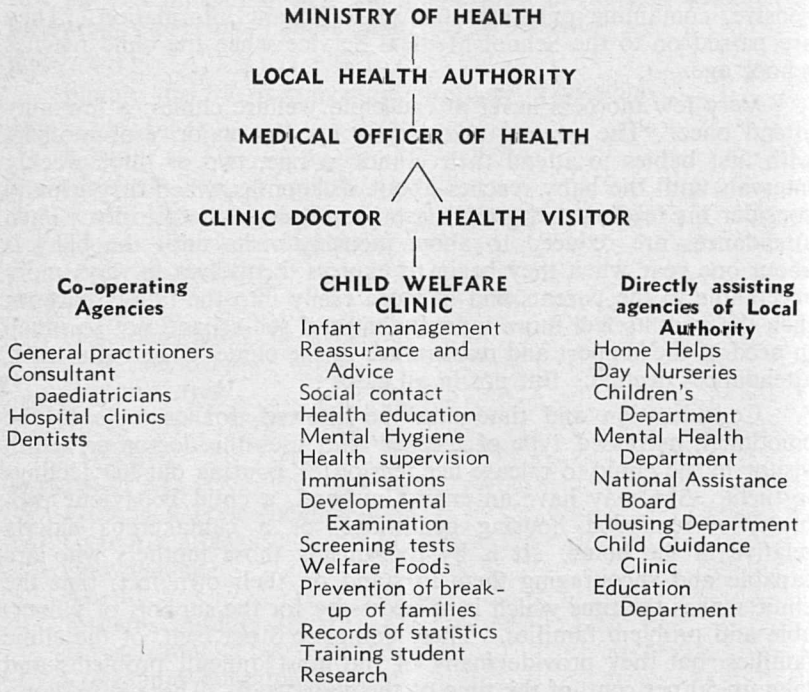
Consideration and time must be allowed, for example to the emotional, harrassed type of mother who uses the doctor or health visitor in the clinic to release her tension by pouring out her feelings to them. She may have an erring husband, a child behaviour problem, overcrowded housing conditions, or a cantakerous elderly relative in the home. It is by recognising those mothers who are capable and encouraging them to stand on their own feet, that the clinic makes the time which is so necessary for the support of vulnerable and problem families. These comprise 3 per cent. of the clinic families, but they provide many of the most difficult problems and take up 50 per cent. of the time of the clinic staff. There is to-day a greater appreciation of the part played by social factors in the origins of physical, intellectual, emotional ill-health and a greater desire to help and to do more in the way of prevention.

The commonest cause of poverty to-day is the large family of children. One may feel like blaming feckless parents; one cannot blame their children. But clinic personnel come to accept all their

families. Support and guidance is given to the whole family, though the actual problem may centre round one member.

Separate immunisation sessions have the advantage that children are not conditioned to associate all doctors with being pricked, but for economic reasons some clinics combine immunisation with routine clinic work.

The routine weighing of children is a controversial subject. Some mothers tend to regard the regular weight checks as the main indication of their child's progress. Remarks about "underweight" may be misinterpreted by the mother, but education is helping them to put weighing in perspective. Mothers are learning that half the babies are of necessity below average weight and also that big babies are not necessarily more healthy. In selected areas in London some years ago, baby weighing as part of the child welfare clinic service was eliminated for an experimental period. Sceptical doctors and health visitors predicted attendances would decline. This was not so and omitting some routine weighing will save time to be devoted to more important work.



The writer wishes to acknowledge with gratitude the assistance of Dr. Dorothy Egan, and especially the support of Dr. R. C. MacKeith and the friendship of many mothers and children at the Salomons Centre.

The opinions expressed in this paper are the writer's own and do not necessarily represent those of the Hospital.

A Mentally Handicapped Child at Home by H. Shrand

Henry was born after a pregnancy uncomplicated by disease or drugs. His mother (35 years old), his father (42 years old) and his sister (15 years old) were well and there was no history of hereditary disease. Henry was perfectly normal at birth and developed well; he smiled at six weeks, accepted solids at 10 weeks, and sat up at five months. Immunisation was started at six months (later than is recommended), when he was given his first injection of "triple antigen" against diphtheria, pertussis and tetanus. About a month later, he began drawing up his legs and flexing his head. "He must have the colic," thought his mother. So she went to the family doctor complaining of Henry's "colic". The doctor responded to her complaint by prescribing an anti-colic mixture.

The misuse of the word "colic" probably had serious sequelae for Henry. A doctor should never accept the parents' diagnosis or use of technical terms or "professional jargon" without analysing the situation which led to their use.

The antispasmodic mixture did not relieve the episodes of "colic" which became more frequent and now Henry no longer attempted to sit up or even say "Dadda". At $7\frac{1}{2}$ months he was given his second injection of triple antigen. The mother, however, persistently visited her doctor, complaining that Henry's colic was no better and was referred to the Paediatric Out-Patients with a note: "Please see Henry C.—Colic. Mrs. C. rather a difficult mum."

The specialist, a keen psycho-somatician, who had a busy out-patient session that morning, was well aware of mother-child interactions and accepted the word "colic" and explained it as a reaction to the mother's anxiety. He reassured the mother all would soon be well.

There are no difficult mothers, they are anxious and worried mothers, and it is the doctor's responsibility to either confirm or refute the cause of their anxiety. Ideally, reassurance comes to mother as she realises her fears are unfounded. A detailed history and complete physical examination with appropriate investigations can be of great therapeutic benefit as the mother sees that "everything is being done".

A careful history would have revealed that Mrs. C.'s anxiety developed after the onset of Henry's symptoms and did not precipitate them. Anyway, the mother was not reassured and she noted a worsening of Henry's symptoms. She met the doctor's wife in the local market, " Henry is not doing well, he gets these starts and turns. Sometimes I don't think he's all there." The doctor's wife, who had worked as a nurse in a neurology unit, thought Henry might be epileptic and suggested that Henry should have an E.E.G., so Mrs. C. went back to the hospital and meets yet another doctor, a new man, who asked Mrs. C. to describe exactly what was happening. "He suddenly bends up his legs, bends down his head—then seems off. It

does not last long but happens so often. He no longer smiles, cannot sit up (now aged 9 months) cannot say 'Dadda' and cannot chew solid foods."

The new doctor immediately considered "lightning" or flexion spasms with retardation and ordered an emergency E.E.G., which showed the pattern of hypsarrythmia, thereby confirming the diagnosis of infantile spasms. No obvious metabolic or other cause could be detected, although there was a possible relationship to the "triple antigen". About that time, "flexion spasms" were in the news, with a few rather exuberant papers claiming miraculous results with steroid therapy. The doctor, influenced by these papers, convinced the parents that after one or two "magic shots" their baby would soon be well. How delighted everyone was when the flexion spasms ceased and Henry started to smile again. "A miracle of modern science," said the satisfied physician, but alas, the respite was but temporary and the spasms recurred, now associated with grand-mal seizures and further retardation.

Parents should be told the true possibilities of any treatment—they will then relish success and yet be prepared to accept the failure. The doctor should be realistically optimistic.

Mrs. C. returned to the out-patient department and, in a room filled with students, the doctor decided she should be told "all the facts". "Your son has a peculiar sort of fit which has made him backward and he will always be so."

Mrs. C. was stunned by the bad news and for many years she resented the presence of those students and how brutally the serious news, involving her son's mental life, had been thrown at her. She resented the formal atmosphere and the fact that she was not given the chance to ask questions.

Having to inform parents that their child is retarded is never a pleasant procedure and should only be done after investigation and consultation have proved conclusively that retardation is, in fact, present. Sometimes it may be necessary to reassess the child a few months later before coming to a definite conclusion. Deafness, blindness, and emotional disturbances should first be excluded and developmental status or I.Q. should be established. Although difficult to generalise, both parents should be interviewed together in an informal atmosphere, ideally in their own sitting room, and they should be allowed to talk. This allows them to air all their anxieties, their feelings of guilt with or without feelings of rejection, their hopes, their misgivings, their own interpretation of signs and symptoms, and so on.

Then the doctor should explain in simple language, with the minimum of professional jargon, the essential facts of the problem. It is important to get across to the parents that we are dealing not only with a particular disease but are concerned about their particular child, a member of their family and community, an individual who needs a special training, a special programme. For the parents of a handicapped child have a long, arduous task ahead, and a sympathetic and guiding hand will help considerably.

Mrs. C. was never given this sort of interview and for months was plagued with depression and blamed herself, her husband, the long interval between the first child and Henry, the injections and the doctors. Henry, now a year old, could just about sit up and could neither speak nor smile. He was seen at monthly intervals in the out-patient department for supervision of his convulsions. No one discussed the question of Henry's training or whether he should be reared at home or in an institution, and at this time the family doctor's advice was, "Don't waste your time with Henry, he is backward, send him to an institution for the backward and have another baby."

To-day, many paediatricians do not favour sending retarded children to institutions and would endorse and encourage the family to keep the child at home. Furthermore, to find a place in a State institution might be almost impossible and private institutions can be extremely costly.

Most mothers will prefer to look after retarded children at home if supported. If the family cannot cope with the situation because of physical exhaustion or inability to take holidays because of their reluctance to take the retarded child with them or because of expense or excessive neglect of the siblings then a temporary or permanent institution should be considered as an alternative. The institutions have also adopted new policies and emphasise the return, whenever possible, of the mentally handicapped child to the community.

Mrs. C. and her husband and her daughter decided to look after Henry at home and give him as much family love and attention as possible. She decided to find out more about backwardness and as she had never seen any other backward children in the borough, she wondered if it was true that they were kept in attics or cellars, or sent to institutions. Was she giving Henry the best opportunity for development by keeping him at home?

Mrs. C. soon met mothers who had retarded children—many of them secluded in their homes because of the social stigma still attached to mental handicap in many cultural groups. Speaking to each other gave these mothers a certain relief as they realised that their problem was not unique and they decided to get together. About this time Henry was being looked after by a Home Care Team from a nearby hospital, who called regularly to supervise Henry's progress. The team supported Mrs. C. in her endeavours, encouraging her work at home. A special "walking" device was brought from the physiotherapy department, which helped train Henry to walk, and special fire guards were recommended to prevent any accidental burns during one of Henry's seizures.

The social worker of the hospital was introduced to Mrs. C. and a co-ordinated effort planned.

The doctor is no longer the omnipotent lone purveyor of medical advice and treatment. The comprehensive realistic approach to the retarded child requires team-work. The family doctor must become the captain of the team, using the services of the paediatrician, psychiatrist, psychologist, teacher, social

worker and, of course, the parents and the siblings. He must be familiar with all social services available in the community. The local authorities should provide special facilities for the education of the mentally subnormal child sometimes needing special arrangements in an ordinary school or, if severely subnormal, admission to a special "training centre".

In practice, the facilities vary from area to area, especially in the mental health services, because of shortage of staff and accommodation, and the long waiting list for admission to nurseries and hospitals.

As there was no local nursery willing to admit retarded children, Mrs. C., with the support of the Home Care team, with advice from a Society for the mentally handicapped, and with the help of the other mothers, organised a small nursery for their retarded children. After much difficulty a nursery teacher, experienced in the care of retarded children was found and each day, ten retarded children would be looked after in the nursery. A voluntary society permitted the free use of a room in their premises—later an impressed donor provided a house and another voluntary society provided a small bus, so that the children could be transported to and from their homes.

Henry is now four years old, attends the nursery each day and will soon be assessed to decide whether he should be admitted to a special "training centre" or a special class in an ordinary school.

What has Mrs. C. accomplished? She has given her son the home life to which every child is entitled and has given him the opportunity to develop whatever talents he possessed. She has encouraged the mothers of other mentally handicapped children to band together, form a special nursery and agitate for further facilities for their handicapped children.

There are approximately 90,000 mentally retarded children in England and Wales, and probably most of them could be cared for at home with adequate sympathetic support and planning. Teamwork is essential if the potential of the retarded child is to be developed to the maximum. Utilisation of the available community services, with advice from the medical and teaching profession and assistance from voluntary sources will all help to ease the trials of the family and help to provide the best facilities and opportunity for the mentally handicapped child. Only when home care is impractical need the child be sent to an institution, but while at home, specialised training should be provided at day nurseries. Then, with understanding, the mentally handicapped should be integrated into the community, giving him the opportunity of a sheltered employment and of living as useful a life as is possible. This new humanistic approach gives a new dignity to the mentally handicapped child and widens his horizon and potential for the future.

THE AMERICAN HOSPITAL OF PARIS

by A. J. RICHARDS

As this hospital attracts many Guy's men wishing to escape from the National Health Service for a few months, I thought an informative article might be of some value.

The hospital itself is situated just outside Paris, in Neuilly, a well-to-do suburb, north of the Champs Elysées. It was originally set up for Americans abroad, being granted a Federal Charter by Act of Congress in 1913, although the first patient was admitted in 1910. It achieved official recognition by the French Government in 1918.

Any American is entitled to treatment here, regardless of financial position, plus anyone else who can afford the high clinic and room fees. Most Embassy people seek treatment here, as do Hollywood stars on location in Paris.

The consultant staff is comprised of only three Americans—all Physicians—and over seventy attending French physicians and surgeons, with a further seventy who may consult, from time to time, at the hospital. The House Staff is comprised of six or seven residents —only single men being accepted—who are housed in a modern building in the hospital grounds. The accommodation is excellent; the meals, which are eaten in the visitors' dining room, can also be excellent at times; at others, plain mediocre—wine is not included, by the way, and has to be paid for.

There are only 160 beds (although a new wing is nearing completion), and of these, 40 are under the American Army, and attended by Army personnel.

As far as the work goes, this is much easier than a N.H.S. appointment, but, as many find, less satisfying.

Three residents are assigned each month to the American consultants (or internists to be more accurate), and do a morning ward-round with them, although there are no wards as such, all patients being in one or two-bedded rooms.

Up to mid-day, these three residents are responsible for clerking in any admissions that come in on the respective floors assigned to each of them. After mid-day, all ward work is usually done by one resident until 6.00 p.m., when the resident on duty for the night takes over, who is also on call for any casualty work.

The ward work is easy, but boring. One soon learns to take a history in French, for the majority of in-patients, in fact, are French. Initial treatment and ordering of investigations is routinely done by the consultant, and in the case of a surgical patient, all pre- and post operative care is the responsibility of the anaesthetist. The resident only orders treatment in an emergency, which is not often. No resident is attached to any of the French consultants, so that even if one makes a significant different diagnosis to him, e.g. salpingitis instead of appendicitis, or finds a "tension" of 300/200, it will not be taken into con-

sideration, for initial treatment and investigation has invariably been started, and the operative wheels are turning before the resident sees the patient. To my knowledge, not one of the French consultants has read any of my histories regarding his patients.

One may well ask, just what is the purpose of being on the wards, in that case? The answer is simple. Since 1954 the American Hospital has been a Member Hospital with the Associated Hospital Service of New York, an organisation which allows Blue Cross and Blue Shield sickness insurance to be used here. One important condition that must be fulfilled is that every patient admitted to the wards must be given, in American phraseology, a complete "work-up" by a resident doctor.

Two residents, occasionally three, during the tourist season, work in the Out-Patient cum Casualty Department, which has good facilities, but is for the most part inefficiently staffed. Working here is far preferable to being on the wards, for one is able to institute treatment, refer patients, or admit them if necessary. The majority of patients attending O.P.D. are American students, a great many of whom are flotsam and jetsam washed up on the Paris Left Bank. Venereal Disease is a daily malady which is seen and treated by the resident; other ailments seen are diarrhoea and vomiting, hepatitis (very common in France), the usual aches and sprains; plus Americans for various immunization vaccines, or just demanding penicillin "shots" for their sore throats.

Of the other residents, one does a surgical appointment, now largely mythical, as the surgeons have started to bring their own assistants from other hospitals. This was considered a good appointment, not because of surgical experience gained, which was nice, but because of being paid per operation. The other resident (if there are seven of us) is usually free. His job is to stand in for anybody sick or on holiday—either officially or unofficially—and generally he has an easy time.

The designation of duties is carried out each month by the chief resident (the one who's been here longest), and a six-month appointment will usually run to three non-consecutive months on the wards, one month in O.P.D., one month surgery (if any), and one month as the stand-in. No one is overworked—night duty averaging once a week, and week-end duty one week-end in three, though never working both Saturday and Sunday nights.

The pay is good, although the higher cost of living must be taken into consideration. Each resident is paid in cash, 1,050 N.F. per month, about £76. There are no deductions from this, the pay being classed as a scholarship, and thus not subject to income tax.

Whatever drawbacks there are about the job, it must be remembered that all the patients are private, and that the hospital functions largely as a clinic, but the atmosphere is a pleasant one. I could go on at length about the French doctor and patient, with their

" suppository ", " vitamins " and " calcium " fixations, but that is a different story. I have merely tried in this brief account to let the future would-be-resident know what sort of a job he's coming to. Obviously to be able to speak French will help you socially and medically, though it's not a necessity—almost everyone who works in the hospital can speak English.

Appointments are from six months up to one year, and provide an ideal break for those who want a rest from N.H.S. conditions, or to study for higher examinations; or for those who want to see Paris or just get away from the stupid English licensing hours. By the time I leave, I will have been here nine months, and can honestly say that I've enjoyed myself so far.

KEATS' HOUSE

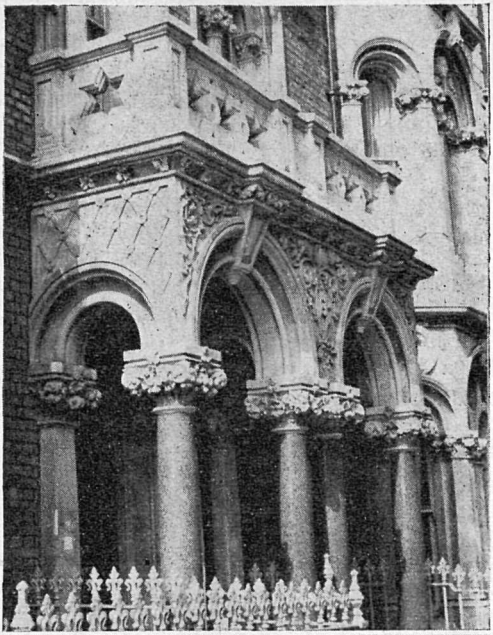
In the days before telephones and motor cars the Governors of Guy's expected junior members of the visiting staff to live close to the Hospital. As suitable residential accommodation was scarce the Hospital authorised the building of two houses at an estimated cost of £4,000 to £4,500, which are now known as Keats' House. By October, 1863, the finished houses were let for a term of 21 years to Dr. Hicks and Mr. J. Cooper Forster at £190 per annum. For many years, until 1914, the houses were occupied by assistant Physicians and Surgeons. After the war, nurses and others lived there.

After the 1939-45 war it was decided to adopt the two houses as private consulting rooms. A name was required for the building and at the suggestion of Professor T. B. Johnston, the then Superintendent, the name Keats House was chosen, in view of the fact that Keats when a student at Guy's lived in lodgings nearby in St. Thomas's street.

In 1965 the exterior of Keats' House was cleaned. This has revealed the attractive red bricks and carvings around the stone surrounds of doors and windows. There are four sculptured heads on the first floor. There is no clue as to their identity. Perhaps readers will hazard suggestions.

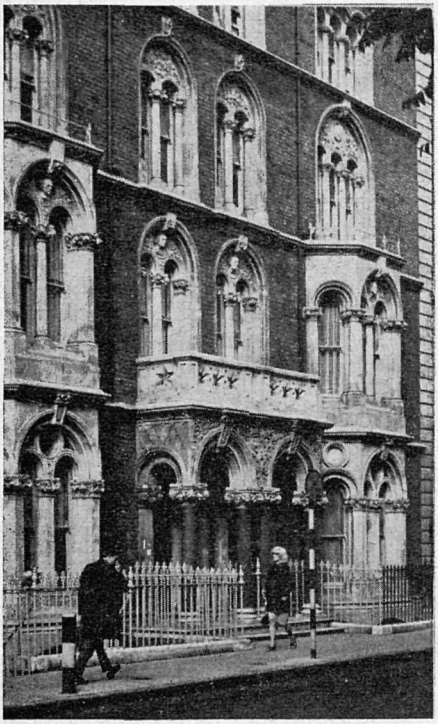
SIR JOHN CONYBEARE.

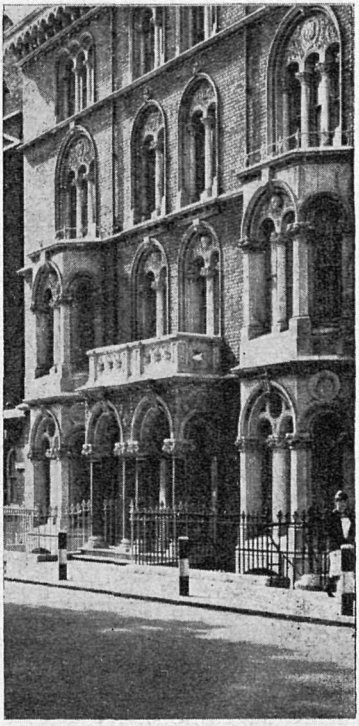
KEATS' HOUSE



Photographs by

MR. F. J. PITTS





EDGAR ALLAN LLOYD, L.D.S.

Edgar Lloyd died in June after a mercifully short illness, but he will live as long as any of his friends live. He was born in Herefordshire; his father, the schoolmaster, in what is still a remote village, and from him he received his education. At 16 he went into a bank at Worcester, but was rescued from this by the 1914-18 war. He joined the Welsh Horse and later transferred to the R.F.C. He was shot down and posted as missing, but turned up wounded as a P.O.W. He escaped from his camp at Freiburg—but only as far as the hole in the chapel wall. After the war he came to Guy's and qualified in dentistry.

When I first knew Edgar he was "Ginger Lloyd"—to a later generation of students " Farmer Lloyd." He attended on only one afternoon a week, but he fully justified the part-time appointment system. No other teacher influenced me more. From him one learned that a patient was an individual and not a dot on the graph, and his common sense and integrity brought one's forming ideas into proper perspective. One knew that his criticism was justified and his sparing praise earned.

During the Second War I was fortunate to become on intimate terms with Edgar and to discover the culture and wide interests which lay beneath what seemed at first a rather austere mask. Intolerant of humbug, his comments on men and affairs were just and pithy—but without malice and served with sardonic humour.

When he retired, he and Eve returned to Herefordshire, where they walked and he fished. It is pleasant to know that on the week preceding his illness there had been a hatch of May fly and Edgar spent his days on the river bringing home good baskets of fish.

He lived life in the round up to the end.

J.W.M.

MR. L. WESTWOOD

"Len" Westwood came to Guy's in 1914 and joined the Physiology Department at the time when Professor Pembrey's laboratory was the main hub of clinical investigation. During the first World War he was in the Army, and though he came back after a spell with the Army of Occupation in Germany, he had been exposed to a war gas and his lungs were damaged. This caused him a good deal of disability during the years, but did not prevent him from doing his work well and cheerfully and he was hardly ever absent.

After 1919 he was essentially a research assistant, helped many people and gained a wide range of experience to make him ultimately the ideal head technician. He assisted Dr. Laidlaw in his work and in instructing students in pharmacology. He continued in his double role of physiologist and pharmacologist for a number of years. He helped Dr. Cook in biochemical work, Dr. Campbell in respiratory and circulatory investigations, and later Dr. Bishop in a wide range of endocrine work and so became a very busy key man. In recognition of all this he obtained the title of Assistant in Research.

When the second World War came he and Dr. Mutch, lecturer in pharmacology, took the department down to Tunbridge Wells. Westwood maintained a small animal house and was able to supervise demonstrations during this difficult time.

Later when Dr. Robson came to Guy's, he was lucky to have the help of Westwood in building up the Department of Pharmacology, and this continued until September, 1964, when, in spite of his courage, he had to give up the struggle and retire owing to increasing bad health and respiratory difficulties.

Westwood was a man of the old school—he did not delegate his duties, but was there, in person, with a smile and encouragement to all. He was a man of great integrity who was held in high regard by all; gentle and considerate and with a sense of humour. We mourn his passing as we mourn the epoch he represented.

Our deepest sympathy goes to his widow and son. We shall always remember him with affection.

PSYCHE and SOMA

By unusual array of circumstance, a throbbing throat, in the middle of which two tonsils and a uvula attempted to have a ball, and a temperature of 101°F., I was forced to seek medical attention. Perfectly aware of the psychosomatic nature of the complaint, and in need only of a few words mainly to the effect that 2nd M.B. is a stepping stone to greater things and many people actually make it, I resolved to visit the local G.P. Swathed in scarves and an overcoat, the bright orange of Guy's standing in gay contrast to a pale grey face, I arrived at 8.45 a.m. at "the doctor's", having been assured by a good neighbour that "he" opened at 9. I was shocked nay, shaken, to find the gateway to my haven barred. A little research yielded 9.30 as commencement of morning surgery. Resolutely I kicked the door only to turn my wan face to the cold brick wall, beaten. I'll be found stiff, ice packed within my joints and covered with a fine mantle of snow in the very best fashion; then he'll be sorry, I grimly thought. Trouble is he's overworked; that's the good ol' N.H.S. My attempts at an appropriate song ended in croaks. At 9.15 the door opened. Prepared to collapse in a fever-ridden heap as soon as this happened, I smiled instead, politely said thank you, and tried to twinkle my disease-glazed eyes—doctors' wives are generally quite pretty. Together with some ten other soles I sat. Deciding to adopt the attitude of illest, should anybody there want to challenge my right to be attended to first, I huddled myself and pulled dramatically out of two faints within five minutes. This having cemented my claim I took a weary interest in the gathering. Nothing of any merit really, an odd baby or two, one lady had apparently fallen over a manhole cover and 'ad 'ad 'er elbow put round the front. Very painful it was too. Naturally, this was the worst case of its kind and had defeated the combined medical skill from infinity knows where. This had necessitated three months orf work an' I've on'y come to change me certificate. I'm claimin', of course. At 9.45 the physician and surgeon blinked his way past twelve people. Ten minutes later, after a cheery chat about how my studies were going, during which I was forced to admit weaknesses here and there, I departed, the possessor of two somewhat old textbooks and a prescription for penicillin. Still, as he said, medical students can't expect sympathy. Convinced that the real cause of the disease is not yet fully cured, my whole man still untreated, I am pleased to say that after 36 hours in bed, alone, but for orange juice, aspirin and penicillin, I am well enough to have written this.

WILLIAM HUGHES.

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CORRESPONDENCE

School of Physiotherapy Michaelmas Ball.

SIR,—The School of Physiotherapy is holding the Michaelmas Ball on Friday, 17th September, 1965, at Quaglino's, from 8.30 p.m. to 2 a.m., to the music of Tommy Kinsman and his band. Besides dinner and dance there will be a Tombola. Tickets are obtainable from any physiotherapy student, price 4 guineas, available until Tuesday, 14th September.

Yours, etc.,

D. STEVENS,
Ball Secretary.

School of Physiotherapy,
Guy's Hospital,
S.E.1.

Guy's Hospital Dental Society Annual Ball.

The Guy's Hospital Dental Society Annual Ball will be held earlier than usual on Friday, November 5th. Tickets will be available nearer the time, from the Dental Ball Secretary, The Dental Department, Guy's Hospital, S.E.1.

Yours, etc.,

STUART ORTON-JAMES,
The Dental Ball Secretary.

International Congress of Dental Students

SIR,—May I, through the courtesy of your columns, thank all those members of the Dental and Medical School Staff and Students who did so much to make the combined congress of I.A.D.S. and B.D.S.A. such a success.

Many of our visitors from overseas and from other Dental Schools in Britain have told me how much they have enjoyed their visit to Guy's and how much they have appreciated the kind and friendly atmosphere.

Yours, etc.,

T. W. NEGUS,
Chairman of the Congress Organising Committee.

Guy's Hospital,
London Bridge, S.E.1.

Student's Essay Prize

SIR,—We are running our Student's Essay Prize again this year, the subject being "Medical Education as I would like to see it". Prizes as before will be £50, £25 and £10 respectively for the three adjudged winners.

The closing date for entries is 1st November, 1965, and entry forms and rules are obtainable from the Editor, Medical News, 2, Bentinck Street, W.1.

Yours, etc.,

DAVID CARRICK, *Editor.*

Medical News,
2, Bentinck Street, London, W.1.

REVIEWS

A SYNOPSIS OF FEVERS AND THEIR TREATMENT.
by James Lawson, M.D., D.P.H. Lloyd Luke. 225 pages. *Price* 15*s*.

Infectious diseases, by their nature, lend themselves to presentation in synopsis form. This eleventh edition has been brought up to date by the inclusion of information about the newer antibiotics and serological methods.

It contains 17 brief chapters devoted to the manifestation and management of the commoner infections and three dealing in general aspects.

There is little to quarrel with in the material included: which is written and printed in a clear and accessible form; and the price is not excessive.

J. R. R. SPURRELL

ORGANIC CHEMISTRY.
G. A. Maw, Ballier, Tindall and Cox. Pp. 214. *Price* 15*s*.

This book is one of a series of concise medical text books which replaces the "Aids" series. New books have been included, but this and others are revised versions by the same authors or their counterparts in the older "Aids" series. Basically "Organic Chemistry" in "Aids" reprinted under a brighter cover and on larger pages. It is admirable that books should be revised periodically, and the material arranged in a more attractive form. "Organic Chemistry" is a great improvement on "Aids" as far as this is covered, and one feels that the material will be easier to commit to memory when headings, formulae and so on are attractively arranged. However, this hardly justifies a price increase of about a half, and while "Aids" can be got second, third, even tenth hand, they should be sought out.

There are chapters on single organic compounds, isomerism, and in the last half of the book, chapters on compounds of biological interest. Examples of groups of compounds given, with brief notes on their properties. More detail could profitably have been included on basic steroid structure, even for a revision text-book. The other chapters fulfil their purpose of supplementary lecture notes, and to jog the memory of the student revising for examinations. There is a very useful final chapter giving quantitative tests for a variety of substances.

ROGER SALT.

HOW TO INTERPRET CARDIAC RADIOLOGY,
by Dr. Daniel Routier. John Wright & Sons, Ltd., 1st Edition, 68 pages Price 8s. 6d.

The Belgian Savoir Interpreter series consists of 24 volumes and was originally published in French in 1955. Following their success, five of these volumes have now been translated into English, of which " How To Interpret Cardiac Radiology" is the smallest and cheapest.

The book sets out to give an outline of how to examine the heart and chest, using a fluoroscopic screen, banning the X-Ray pictures to the province of the radiologist. A description of the thoracic cage is first given, followed by a more detailed study of the heart and major blood vessels. The study of the hila and lung fields is then briefly described. The examination of the four chambers of the heart is gone into in more detail and this is followed by a short description of angiography. The second part of the book describes the abnormalities found on fluoroscopy in certain common cardiac disorders both congenital and acquired.

To the student, this book is of somewhat uncertain value, since it describes a technique which he is neither expected to learn nor given a chance to practise. The assimilation of a description of something which is purely visual accompanied by only sixteen diagrams would not prove an easy task even to the more aspiring student.

For the postgraduate, studying cardiology, the book may be a simple introduction to the subject. However, much more detailed knowledge would be required and larger text books would need to be studied. Although, therefore, the book is well written, its appeal does appear to be rather limited.

P. GARCIA-WEBB-SHARP.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Registrar in Clinical Pathology,** with duties commencing as soon as possible and appointment until 30th September, 1966, in the first instance. Forms of application are available from, and should be returned to, The Superintendent, Guy's Hospital, not later than **11th September, 1965.**

GUY'S HOSPITAL, S.E.1.

A 10-month course for female **Dental Hygienists** will commence in April, 1966. Candidates must be at least 17 years of age and should have obtained a minimum of four "O" level subjects in the G.C.E. Application forms, which should be submitted by **27th September, 1965,** may be obtained from the Department of Preventive Dentistry, Guy's Hospital, S.E.1.

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UNIVERSITY OF LONDON

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ROYAL COLLEGE OF SURGEONS OF ENGLAND

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1st Class Honours

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E. Elias J. H. Tripp

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PASSIM

Ignác Phillip Semmelweis

August 13th, 1965, marks the centenary of the death of Ignác Phillip Semmelweis. Born in Buda, he received his medical degree in Vienna in 1844, and in the same year was appointed assistant professor in midwifery under Klein. At this time the maternal mortality rate was eighteen per cent and to his dismay Semmelweis realised that it was even higher in those wards attended by student accoucheurs. The death of a colleague, from a dissecting wound incurred during a post mortem, haunted the young doctor and he became convinced that his friend had died of the same disease which decimated those lying-in.

From these observations he developed his theories of the aetiology of puerperal fever. First, that it is conveyed to the woman by cadaveric particles on the examining finger; second, that it may be conveyed from living organisms; third, that putrid material may find its way through the air to the genitalia; fourth, that putrid material may be conveyed to the woman by foul linen and, fifthly, he postulated that a woman could infect herself by retention of material in the birth canal. On these grounds he instituted a thorough regime of chlorine disinfection in his wards, free ventilation and isolation of infected puerperae. The mortality rate was reduced sevenfold.

There was strong opposition to his work from Scanzoni and Carl Braun, the former being later credited with the introduction of scrubbing the hands with a brush and employing potassium permanganate as a disinfectant and the latter plagiarised Semmelweis' work when he published a paper declaring that puerperal fever was not a disease *sui generis* but merely a variety of pyaemia. Klein, his superior, became jealous and eventually drove Semmelweis from Vienna with the label, crank. He settled in Pest and in six years he brought the maternal mortality level to below one per cent. In 1865, however, he returned to Vienna not triumphant but to the hospital for the insane, where he died of an infection resulting from a hand injury. Ironically, he died from the disease which he did so much to eradicate in puerperae.

Only the first of his tenets had not had a precedent, White had already published a monograph on the importance of sanitation in the sick room, and Alcock and Lisfrank had used chlorine solution as a disinfectant twenty years before Semmelweis. He applied his sensitivity and powers of observations to the art of healing in an era of myth, in a country that shunned him and amongst bigoted colleagues.

THE PUBLIC EAR

The recent Government White Paper recommending a new approach to the problems of juvenile delinquency, must surely be welcomed. Some of the proposals are aimed at taking the treatment of these children away from the aura of the courts and placing it in the hands of people who are professionally trained in dealing with these matters; doctors, social workers and teachers, working in conjunction with the child's parents.

However, the paper has received an indifferent welcome from the public and restrained criticism from the professions involved. The sociologists have accepted the recommendations in principle as an advance in social practice but have criticized the working details of the report in terms of the inadequacy of the present machinery of social services. In general, the public's reaction has been one of conservatism. The idea of understanding and prevention rather than punishment and deterrence has been difficult to accept. In most minds the birch still seems to be inseparably linked with delinquency. This is only part of a pattern of the public's reaction to many kinds of social reform. Here there is a breakdown in communication, a lack of dissemination of knowledge from the professions to the public.

The professions concerned with social matters are essentially servants of society but have more than just this formal responsibility. There is a broader responsibility which involves guidance and leadership and it is here that the social professions are failing in their duties to the public.

The medical profession is also guilty of this. There is an apparent absence of formal pronouncement on social matters from the profession's representative bodies. None of the colleges, councils, committees, associations, fellowships, guilds or unions of the profession have the responsibility of disseminating knowledge or social guidance to the public. They are all mainly concerned with safeguarding the doctors' lot. This becomes quite evident when the last few months of the profession's tangled financial manoeuvres are considered against the silent background of medical opinion on the white paper. The profession, concerned with its own internal politics, is becoming oblivious to its important role in the leadership of society, and respect is slipping away. General medical opinion and guidance on social problems should be given to the public so that social reform might become more acceptable.

GUY'S DIARY

SEPTEMBER.

EXHIBITION.		*Head Injuries.*
23rd Thurs.	1.00	PROFESSOR G. B. ONG (Professor of Surgery Hong Kong University). Clinical Lecture. *Carcinoma of the Oesophagus.*
28th Tues.	1.00	PROFESSOR MARIO GONAZLEZ ULLOA, of the Dalinde Hospital, Mexico City. Clinical Lecture. *"Results Obtained In the Integral Correction of the Profile".*

Some Observations on Hospitals and Surgery in the Netherlands

by

D. K. C. COOPER

Last year when on holiday in the Netherlands, I took the opportunity of visiting three of the major hospitals of that country. I was particularly interested in the hospital buildings themselves, in the organization of the casualty services, and in seeing a little of the surgical work in each of the centres I visited. I was also interested in comparing the training that a young surgeon undergoes in Holland with that which he undergoes in this country.

My first stay was in the beautiful city of Amsterdam, where there are three major hospitals—two of which are teaching hospitals of the University. It was to one of these, the Wilhelmina Gasthuis, a hospital of some 800 beds, that I made my first call. The hospital consists of numerous buildings widely spaced over a large area. Communication is therefore lengthy and, as there is no subway system, in bad weather it is also uncomfortable, as I learnt to my cost, for it was raining heavily while I was there. Distances between one part of the hospital and another are frequently far enough to warrant the use of a car.

I was readily given permission by the authorities to visit the Casualty Department (Dept. of Traumatology) and one of the doctors working there kindly offered to show me around. The department is organized on very similar lines to that at Guy's, but there is one major difference. A doctor at the hospital's main entrance "directs" patients, after brief questioning as to their complaints, to the correct department. The Casualty Department, therefore, deals only with true " casualties "—sprains, fractures, head injuries, traffic accidents, lacerations, etc. "Medical" patients, e.g. asthmatics, etc., ear, nose and throat patients, patients with eye lesions, etc., all of which form such a large part of the work of the Casualty Department at Guy's, are directed straight to the appropriate department, be it internal medicine, ENT, ophthalmological department, etc., where the patients are seen by the appropriate resident. As a result, the casualty officers see by no means such a wide range of clinical material as their Guy's counterparts. However, this system of selection seems suitable to the Dutch Casualty Officers as they are all specialising in surgery. This selection of patients means that the number of attendances at the Casualty Department is less and therefore only three doctors, assisted by students, are required.

The actual building consists of minor operating theatres, plaster rooms, etc., as at Guy's. A clinic is held each morning for re-attendances and for dressings on similar lines to our Back Surgery clinic. The department differs in two interesting features from

our own department. The first of these is the presence of a small ward containing some twelve beds, into which the casualty officer himself can admit patients for observation overnight, and can extend their stay for two to three days or even longer if he feels this to be necessary. This is particularly useful, of course, for patients with suspected head injuries. Secondly, no radiographers are on duty at night. It is the duty of the Casualty Officer himself to expose and develop X-ray films. A resident radiologist can be called to give a second opinion on films at the Casualty Officer's request. As only one Casualty Officer is on duty at night, this added task of taking and developing X-ray films is not an uncommon cause of delay in seeing further patients.

At this stage it is of interest to compare the Casualty Department at the Wilhelmina Gasthuis with that at each of the two other hospitals that I visited. At the Academisch Ziekenhuis in Leiden, the Casualty Department is administered by four doctors, assisted by some six to eight senior students. There is a similar process of patient selection at the main gate of the hospital, but in Leiden it is carried out rather unofficially, though very successfully I understand, by the porter. At the week-ends and at night, when the other departments are closed, the Casualty Department receives all emergency patients, irrespective of the complaint. Patients re-attending for dressings, etc., do not come to a special clinic, but attend at whatever time they choose. A radiographer is on call for twenty-four hours of the day, and a resident radiologist is available at any time for consultation. There is no ward into which patients can be admitted for observation, and in fact, due to a shortage of surgical beds, no patient can be admitted purely for observation, and all such patients are discharged home to be followed up by their general practitioners. The practitioner takes over the observation and care of the patient and refers him back to the hospital only if necessary.

At the Dijkstra Hospital in Rotterdam, of which I shall say more later, all patients, both medical and surgical, are taken to the Casualty Department, but if the complaint is of a "medical" nature (and this can be confirmed either from the doctor's letter or from a few well-directed questions) then the medical resident is called immediately, the Casualty Officer having no further responsibility for that patient. This system suggests that the Dutch patient is better trained than the corresponding Borough patient and only attends the hospital when he is a true surgical casualty, or at his doctor's request. If the house physician or E.N.T. house surgeon at Guy's were called to see all patients within their field of medicine who attended our own Casualty Department, then these residents would surely have no time for any other work.

As in Amsterdam, the doctor on night duty exposes and develops his own X-ray films, the radiographer on call having to be brought in from the centre of Rotterdam if required. Two follow-up clinics are held each day, thus spreading the considerable load of dressings, etc., carried out at such a clinic.

The Dijkstra Hospital is noted for its Department of Traumatology, which is very busy seeing many serious accidents, and, in fact, dealing with all of the head injuries of Rotterdam as it is the only hospital possessing a neuro-surgical unit. The director of the Department, Dr. von Slikke, and his staff hold a short daily conference, one of which I was invited to attend, at which they view all of the X-ray films taken during the previous twenty-four hours. The radiological findings and subsequent treatment of the patient are discussed. Such conferences give the "residents" an opportunity to discuss any patient who has been of particular clinical interest, and are therefore of considerable educational value. The director is also given the opportunity of checking the work of his staff. The radiographs have already been seen and reported on by a radiologist, and thus a second opinion is readily available to the traumatologist if required.

The system of admitting head injuries was identical with that at Guy's, the patient being admitted into a general surgeon's bed unless a neuro-surgical opinion was required.

Returning to the Wilhelmina Gasthuis in Amsterdam, my "guide"—a Dr. Vrind—then kindly took me to the surgical wards and described some of the work of the Department of Surgery. The Department is very active under the direction of Professor Dr. Boerema, whose main interest lies in the use of high pressure oxygen therapy, a field of medicine in which he is a pioneer. I was fortunate to see a patient undergoing treatment in the huge pressure chamber. The chamber is used primarily in vascular disease, especially in peripheral vascular disease, and several cases of imminent gangrene have been reverted and improved considerably by exposing the patient to a course of therapy using oxygen pressures of 2—3 atmospheres. Patients with retinal vessel thrombosis have had their sight saved and improved following a course of treatment. The patient I saw receiving treatment had peripheral vascular insufficiency and was undergoing a course of therapy at 3 atmospheres, each session in the chamber lasting for two hours. The sessions were daily for the first two weeks and then at decreasing intervals. Several successfully treated patients were attending as out-patients and were receiving "maintenance" therapy about once each week. There are no uncomfortable after-effects of a session in the chamber.

One of the "assistants" (registrars) in the department is using a new German instrument for removing the dead superficial layers of the skin in partial thickness burns. These layers are removed under a general anaesthetic by a "sand-papering" technique until just the basal layers of the skin remain. The area is then bound with sterile bandage and left for several days until the skin has regenerated. The removal of the dead superficial layers is said to considerably reduce the risk of infection and, although only some 30 patients have as yet undergone this treatment in Amsterdam, the results are encouraging.

Another assistant, Dr. Hugo Reinders, has carried out considerable work on mediastinoscopy (a new technique of which I had heard

little as yet at Guy's), and, in fact, has recently published his doctorate thesis on this subject. Mediastinoscopy is of Swedish origin, but the Amsterdam surgeons were the first pupils of the Swedish originators. Dr. Reinders and others were concerned with the large number of thoracotomies carried out on patients with carcinoma of the bronchus in whom the condition at operation was found to be inoperable, the patient therefore being exposed to a considerable operation to no avail. Mediastinoscopy is a simple procedure and, in careful hands, has proved a very safe procedure, by which a biopsy of a mediastinal lymph node can be taken (or several biopsies taken from several nodes). If the lymph node sections show involvement with neoplastic tissue, the patient is considered inoperable and thoracotomy is therefore not carried out; if neoplastic involvement is not demonstrated, a thoracotomy is performed for removal of the lobe or lobes as the case may be. The number of inoperable cases found at these subsequent thoracotomies is markedly reduced over the previous series. Dr. Reinders' results appear very encouraging, the discomfort of a valueless thoracotomy to the patient being overcome, and the time wasted by the surgical team being greatly diminished.

I was fortunate to be able to watch a mediastinoscopy being performed in the operating theatre. The procedure was simple and was carried out by a surgeon assisted only by a theatre sister who had scrubbed up. The patient was given a general anaesthetic, a low tracheostomy incision was made and, after separation of the subcutaneous tissues, the mediastinoscope—a simple, short, tubular instrument—was inserted into the chest. The instrument contained a light; the surgeon located a lymph gland, preferably on the suspected side of the lesion, and removed a piece of it by the same procedure as he would take a biopsy at any other endoscopic examination. Haemostasis was obtained, the instrument withdrawn, and the wound closed. Bronchoscopy is often carried out at the same session.

Most of the surgical wards at the Wilhelmina are small, containing up to 12 beds each. There is a recovery ward into which all post-operative patients go even after the smallest operations (involving a G.A.) until they have recovered from the immediate effects of the operation. There is a separate recovery ward containing two beds for cardiac patients, and the post-operative care of these patients appeared very similar to that at Guy's.

The department also has a well-equipped research floor with an animal house and several operating tables. There is also a comprehensive library. One could not help but be impressed.

A general surgeon in the Netherlands undergoes six years post-graduate training in a professorial unit, and during that six years he spends approximately six months in urology, six months in orthopaedics, several short periods in casualty work, and the remaining time in general surgery which, in Amsterdam, includes some thoracic work. If he wishes to specialise further he spends a further period of study of 1—2 years in a unit specialising in that particular field. The Dutch prospective surgeon has one big advantage over his British counterpart. He has no examinations to pass during his post-graduate train-

ing, though he is encouraged to carry out research work for his doctorate thesis. Housemen seem non-existent in the Netherlands—all the work being done by the assistants who are of registrar status, each of whom has a certain number of beds under his care. One or more assistants resides in the hospital each night taking care of all the beds, and dealing with all emergency admissions.

As I have already mentioned, my second call was at the Academisch Ziekenhuis in Leiden. I was fortunate to be able to watch the head of the well-known Department of Thoracic Surgery, Professor Dr. Brom, carry out an aortic valve replacement, using a prosthetic Starr valve. The immediate post-operative care and the organization of the Recovery room was very similar to that at Guy's. In routine use, however, is a machine for the estimation of blood volume post-operatively. This machine is also used in Amsterdam, and both hospitals confirmed its reliability, though its superiority over what can be gleaned from physical signs and venous pressure readings alone is not yet certain. The patient is injected with a known quantity of radioactive iodinised human serum intra-venously, and after ten minutes a specimen of blood is taken and the radioactivity calculated by the machine. The total blood volume can then be easily calculated.

One interesting feature of the post-operative care is that each evening a senior medical student remains with the patient in the recovery room—he even eats in the room—and is responsible for observing the patient carefully and attending to any minor matters. He calls for the assistant on duty if he is at all worried about the patient's condition. The student is paid a small sum for this work.

During the afternoon I attended two conferences with Prof. Dr. Brom and his staff, together with representatives from the departments of anatomy, pathology and cardiology. At these conferences the anatomy and pathology of hearts of patients who had been unsuccessfully operated on were discussed. Conferences on other aspects of the work of the unit occur on four afternoons each week. Attending such conferences at Leiden and elsewhere one could not but gain the impression of a very positive approach to the post-graduate education of the young Dutch surgeon. A note on his training seems appropriate here.

An assistant can be said to be "apprenticed" to a professor or to a consultant surgeon who directs his studies. The assistant benefits from the reputation of his tutor, but the tutor's reputation is also enhanced, of course, if his pupils gain for themselves a good reputation by the standard of their clinical and research work. Both master and pupils take pride in the reputation and standard of their school of surgery. Under his tutor's guiding hand, with the stimulus of his fellow pupils, and with the excellent facilities for learning that I saw at these hospitals, the young surgeon can develop rapidly. This tradition of studying at a school of surgery under one master surgeon seems to be stronger in the Netherlands than in England, where the idea of apprenticeship seems to be less obvious to-day, a young surgeon moving from hospital to hospital assisting various surgeons and

not having his surgical education guided by any one tutor. I believe that to learn from several surgeons at various hospitals broadens the outlook of a young surgeon and increases his knowledge, but in his early days the continuous guidance of his studies and of his technique by one teacher must surely be of great value. In England the post-graduate is so often appointed to a post for six months or one year before being forced to move on to another post where he has to change his methods and ideas to fit in with techniques and opinions there.

Once appointed to a hospital as an assistant, the young Dutch surgeon knows that he will be working and studying there for six years, until, in fact, he is considered a qualified surgeon. His British counterpart has the worry of applying for a new position every six months or one year, and apart from the upheaval caused by having to move from time to time, and become familiar with a new building and with new methods of surgical treatment, he is faced with the worry of not being reappointed or not being selected for any new position for which he may apply. This, of course, tends to keep a young surgeon "on his toes", and the competition keeps the standard high, but nevertheless, it is surely not the best atmosphere in which to train or in which to carry out any long term research work.

On the second day of my stay in Leiden I watched a cardiac operation in which a Rygg bubble oxygenator was being used. The Department of Thoracic Surgery has been using this disposable oxygenator for some time now and probably has more experience with it than any other unit in the world, including Rygg's own unit in Denmark. The Leiden surgeons have found it very successful even for patients who are forced to undergo cardio-pulmonary by-pass for several hours.

Much of the work of the department was described to me by an American surgeon—a Dr. Farrow—who was working there as an assistant. One fact that impressed me considerably was that the entire surgical staff, including many of the nursing staff, overcame any language problem that Dr. Farrow or guests might have by speaking in fluent English whenever necessary. It must be remembered, however, that most Dutch medical students study from textbooks written in English or German or, occasionally, French, and therefore a sound knowledge of one or more of these languages is essential. Few medical journals are published in Dutch, and in order to keep abreast of modern advances, the Dutch surgeon must have a command of another language, preferably English.

Research aspects of the work of the department at the moment include liver transplantation (as a preliminary to attempts at lung transplantation), and perfusion techniques using high pressure oxygen. The hospital has a large oxygen chamber which is only being used experimentally at the moment. Neither at Leiden nor Amsterdam are they carrying out work on oxygen therapy at increased atmospheric pressures coupled with radiotherapy in the treatment of malignant tumours.

In Leiden, as in Amsterdam, the wards are smaller than at Guy's, containing about twelve beds each. Post-operatively all patients regain consciousness in a Recovery Ward before returning to the general wards, a system recently introduced in Guy's.

A recent acquisition to the Department of Surgery in Leiden is the installation of a system of black and white closed circuit television, that links one of the main operating theatres with the main lecture theatre and the departmental library. I sat in comfort to watch one of the residents perform an iliac endarterectomy; the quality of the picture and the view of the procedure were excellent, making the operation very informative. Much vascular surgery is carried out in the hospital, as the Professor, Dr. Vink, has a particular interest in this field.

My third and final visit was to the Dijkstra Hospital in Rotterdam, where I was shown round by Dr. Heyl, a surgical assistant, and another friend of Dr. Vrind, of Amsterdam. If I remember nothing else about my short stay in Rotterdam, one thing I shall never forget is the size and magnificence of the Dijkstra Hospital. It is the most imposing, and to my mind the most beautiful, hospital I have ever seen. Much of Rotterdam, including one of the major hospitals, was destroyed during the Second World War. The new hospital is situated in spacious grounds midway between the "West End" of the city and the docks. The entire building has been built with the same materials, giving it a uniformity unusual in most hospitals. One massive block containing the wards and theatres rises to twelve stories high, and from this two wings project at 45 degrees, containing the various out-patient departments, casualty department, administrative offices, pathology laboratories, etc. One factor that adds to the atmosphere of grandeur and size is the main entrance. As one walks up the impressive flight of stone steps, one is faced by a seemingly endless line of towering glass doors through any one of which one may enter the vast marble entrance hall. One might be entering, not a hospital, but the latest Hilton Hotel or the American Embassy in Moscow, built specially to dazzle the Russian eye.

From this description it is easy to realize the vast cost of the hospital, a cost which, of course, went up in leaps and bounds even as the building was being erected; so much so that certain luxuries, such as air conditioning throughout, which appeared in the original plans, had to be left out of the completed edifice. However, the final result, even on this curtailed budget, which runs into many millions of guilders, is very impressive.

There is only one open ward in the hospital, that being the Recovery Ward, all of the other beds being in single, double or four-bedded rooms. Interestingly enough, the Recovery Ward has never been used, due to a shortage of nurses. Whether this is because the single room system requires more than the usual number of nurses, I did not find out. The fact, however, that even this magnificently modern hospital could not attract a full complement of nurses demonstrates the nursing problem in the Netherlands. The hospital contains 900 beds, and caters for nearly all of the specialities, though

paediatrics is a notable exception, all children being treated at one of the other two large Rotterdam hospitals.

The operating theatres were vast in size, floored with marble and walled with tiles, suggesting a luxury bathroom. The surgical staff's attitude to infection was certainly far from strict. For example, I was allowed into an operating theatre that had been used that day and would be used on the following day, wearing my normal clothes with no gown, cap, mask or overshoes. This might just have been allowed in the theatres in Old Guy's House some years ago, if my memory serves me correctly, but most certainly would not be tolerated in New Guy's House. I was even more amazed to hear that the director of the Department of Surgery did not wear a mask while operating. Yet with all of these "heresies", the rate of post operative wound infection is no higher in the Dijkstra than anywhere else in Holland. This fact gives one food for thought when considering the expense and inconvenience of taking precautions against contamination and the spread of infection in operating theatres. The lack of post-operative wound infection may well be connected with the single room system as opposed to the open ward. In contrast to the almost casual approach to infection in the operating theatres, great pains are taken over infection in the bedrooms. When a patient is discharged the bed itself and all of the linen used goes in a special lift to the top floor of the hospital, where a central sterile supply department is situated together with a special unit for cleaning the bed and linen. The bed itself is virtually sterilised and fresh linen put on it before it is returned to the bedroom, which has also been thoroughly cleaned.

The size of the hospital, particularly of the main block which is long and narrow, gives rise to problems of communication and of physical strain to staff, particularly nurses. Already in the three years since the hospital was opened, two nurses have suffered from "march" fractures from walking the vast distances within the hospital. There is, however, an excellent system of lifts between floors.

The hospital is not a teaching hospital at the moment, though plans are under way to make it so within a few years. Students from Leiden, Utrecht and elsewhere can, however, complete part of their studies at the Dijkstra, and several do take advantage of this arrangement, working especially in the Casualty Department (or Department of Traumatology) which is very busy as the hospital serves both the main part of the city and the docks. Docks, as we know at Guy's, are the source of numerous accidents.

Little research is carried out at the Dijkstra, and one felt that something of the academic atmosphere present at Amsterdam and at Leiden was lacking, probably because the hospital is not yet attached to a University as a teaching hospital. When this occurs and an academic influence is added to the outstanding facilities that the hospital already possesses, then the Dijkstra Hospital in Rotterdam will surely be a very attractive one in which to train and work.

Having completed this short tour of three of Holland's major hospitals, I was left with two impressions that will remain with me

even when the details of what I saw are forgotten. The first is the extreme kindness and hospitality shown to me by the doctors working there. I was invited to their homes and taken out to dinner on several occasions. I was not allowed to return their hospitality—at least, I was told, not while in Holland. When I visited the Netherlands, I was a fairly newly-qualified doctor, and to find such hospitality so readily offered to me introduced me to that bond of friendship found between members of the medical profession.

Secondly, I learned at first hand to appreciate the value of finding out how other doctors and surgeons work, what their current interests are, and what new ideas and techniques they have introduced. I can now understand why doctors, and surgeons in particular, are such keen travellers.

The new facts that I learnt, the ideas that I was introduced to, and the innovaters that I met, added to throw new light on to old subjects. I was stimulated to work to try to put into practice what I had learned, and more important, I was stimulated to think a little more deeply into my own ideas, beliefs and methods, and to pick out the good from the bad.

INTERNATIONAL CONGRESS OF DENTAL STUDENTS

The combined British Dental Students' Association and International Association of Dental Students' Congress was held this year at Guy's Hospital Dental School between August 13th and 22nd. Students from some fourteen countries as diverse as Czechoslovakia, Jugoslavia, Japan, Iceland and America attended. Sweden, Finland, Germany and Holland were all especially well represented. The British participants hailed from thirteen schools. The 190 students were accommodated in two London University Halls of Residence and all the academic papers were read and meetings held at Guy's Hospital.

The British arrived first on Friday, the 13th, and the following day they held the 1st session of their A.G.M., at which the majority of business was settled. International students trickled into London throughout the week-end, and all those students who had arrived by Saturday, celebrated that arrival at a cocktail party and dance at the Royal Dental School, sponsored by the Metropolitan branch of the B.D.A. Sunday saw the remaining delegates descending on London—these included a party of Irish delegates who arrived at one Hall of Residence at 6 a.m.! Student papers submitted for the B.D.S.A. Essay Competition were read in the afternoon. The winning essay was by Ann Hargreaves, of Liverpool.

The Congress was officially opened on Monday, August 15th, with speeches of welcome by Mr. F. S. Warner, Dean of the Dental Studies at Guy's, and Professor R. D. Emslie, Senior President of the B.D.S.A. These were followed by two excellent academic papers. The first was by Professor W. J. Tulley entitled " The Race for Braces," in which

he suggested that about 25% of all children really needed some form of orthodontic appliance, but only 7% required complex appliances, and that orthodontic treatment could not basically influence the skeletal pattern. He showed some intriguing film tracing the histories of orthodontic patients from 3 years old to some 15 years later.

Professor Emslie followed with an absorbing discourse on dental diseases in Nigeria and the Sudan. He concentrated mainly on the study of cancrum oris and Vincent's diseases and discussed the predisposing factors involved. The afternoon passed quickly with the students visiting the Palace of Westminster and the Houses of Parliament. In the evening a highly successful party was held in the new East Wing of Guy's Hospital.

The I.A.D.S. held the first session of their A.G.M. on Tuesday, while the rest of the Congress participants visited the new dental school of University College Hospital. All were very impressed with the work and equipment on display. In the afternoon, Professor Maury Massler, the Director of Post-graduate Studies at the University of Illinois gave a most outstanding lecture on oral habits, origin, evaluation and modern concepts of treatment. He held his audience enthralled while discussing the importance of remembering that a mouth belongs to a human being, and that it is not a contrivance designed to try the dental student. Mr. R. O. Walker then gave a highly informative paper on some aspects of dentistry in Britain to-day. This dealt with problems presented by the N.H.S., and how they tended to limit the standard of dentistry practised. He showed statistically that the amount of conservative work in England has increased over the last few years, while there has been a decline in the more radical practice of extracting teeth.

After posing for a mass photograph, the students left in a flurry of coaches on an intensive tour of London, which terminated in a big East End tavern, where delegates were entertained in traditional fashion! The evening was voted a most memorable occasion.

Wednesday was devoted to pleasure, and the day was given up to an excursion to Oxford, Stratford and Coventry. Unfortunately, the coaches were unable to stop in Oxford because of the shortage of time. The delegates were, without exception, deeply impressed with Coventry Cathedral and its modern controversial design. The beautiful weather also showed them the English countryside at its best.

The much heralded symposium, " The Role of Industry in Dental Research," took place on Thursday. A different approach to the title was provided by each of the four speakers. Mr. Colin Davis gave the introduction and spoke of the work of the Oral Hygiene Service. He was followed by Mr. Graham Davies, who spoke of the way in which industry assisted in basic research. Mr. Clifford Pugh discussed the manufacture of toothpaste, and how its constituents were determined. Mrs. Doreen Wedderburn completed the symposium talking of the biologist's approach to dental disease. The symposium provided a novel approach to lecturing which appealed very much to the students.

A highly successful visit to the Shell Centre for tea, films and the viewing gallery completed a very pleasant afternoon. The major

excitement occurred when one of the lifts came to an unexpected halt between the 17th and 18th floors, and its occupants spent several uncomfortable moments before it speeded on its way.

The final academic lecture of the week was given on Friday afternoon by Mr. Norman Rowe, who spoke on "Modern Concepts of Oral Surgery." In his lecture, the delivery and style of which was an immaculate example to any aspiring lecturer, Mr. Rowe covered a wide range of reparative and reconstructive surgery of the face and jaws, examples of which were illustrated from his magnificent collection of colour transparencies.

A Clinical Demonstration at Guy's Hospital Dental School completed the academic side of the Congress. These Demonstrations, arranged by two final year students, provided a comprehensive insight of the clinical course at Guy's, as well as illustrating examples of advanced operative techniques, surgery and research. The evening was spent on a boat trip from Tower Pier to Battersea Funfair, into which the students disappeared, not to be seen collectively again that night. Saturday morning was spent in completing the remaining I.A.D.S. business, and in the election of the new B.D.S.A. Officers.

The annual Ball and Dinner was held at the Europa Hotel. A lavish affair, it provided a suitable climax to a memorable week.

The organisation of any Congress is never an easy task, especially when in London and undertaken at short notice. However, by means of sound leadership, hard work, painstaking planning and courage to ask for the impossible, a conference was organised of which British Dental students have every reason to be proud. Under the Chairmanship of Tim Negus, a final year student of Guy's Hospital, the organising committee put on a conference which ran smoothly (or appeared to do so!) in every department, be it catering, clinical demonstrations, academic lectures or accommodation and transport.

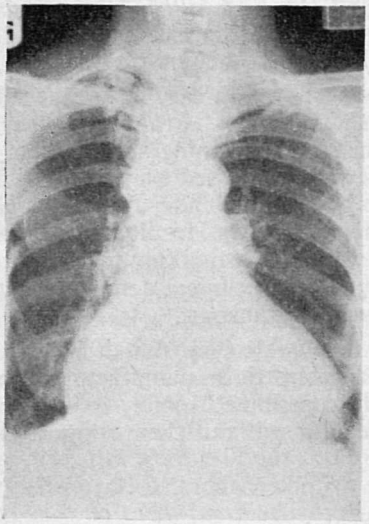
So many people have been of invaluable help that it would be invidious to mention names, but as a group those manufacturing and trading companies who so generously contributed money to the Congress fund must be specially thanked for without their support this congress could not have taken place.

JANET HOCK.

ACHALASIA OF THE CARDIA AND OESOPHAGEAL DIVERTICULUM

by E. N. Wardle

One of the best recent reviews of Achalasia of the Cardia and its complications, made by N. R. Barrett (1) makes no mention of the possible association of epiphrenic diverticulum with achalasia. A large aesophageal diverticulum simulating achalasia was successfully operated on and reported in detail by R. H. Franklin et al. (2). The case reported here is remarkably similar.



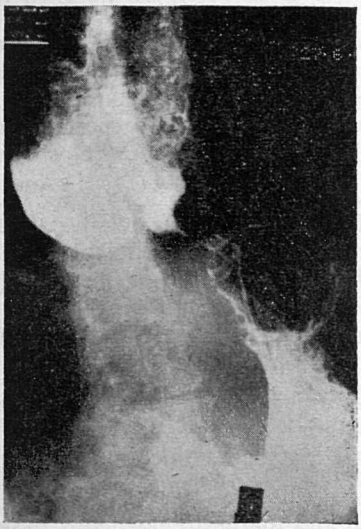
F.T., a lady aged sixty-eight, was admitted on 20.5.64 with a posterior myocardial infarct. She had previously had a coronary thrombosis on 16.3.64.

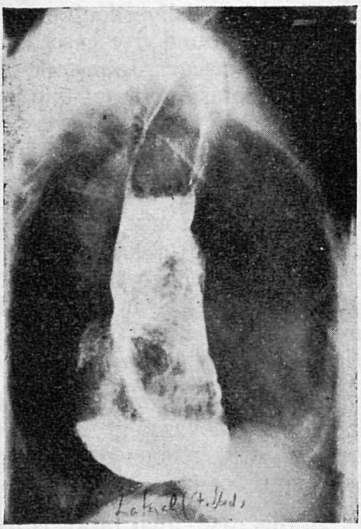
Apart from shortness of breath following her infarction, her main complaint was of difficulty in swallowing by which she had become increasingly embarrassed since 1938, when she was aged forty-two. At first her symptoms had been ameliorated by swallowing a mercury bougie and on one occasion by the use of a Stark's dilator, and she carried on well until June 1961. At this time her disability began to increase such that she could only take soft foods, and liquids were difficult to swallow. She also had a burning sensation at the lower end of the sternum, accompanied by a feeling of food sticking at this level.

Examination in July 1961 revealed a thin lady who was slightly pale (Hb. 78%) and with a blood pressure of 210/100 and evidence of aortic incompetence. Barium swallow showed appearances thought to be those of achalasia but with an associated large epiphrenic diverticulum. This was at the Royal Free Hospital, where she then had an oesophagoscopy on 10.7.61. The instrument passed straight into a large dilatation of the lower oesophagus, in which were large quantities of fluid. There was no evidence of ulceration or neoplasm, but there was diffuse inflammation of the wall of the lower oesophagus.

On 21.7.61 she was explored through the abdomen and a Hellers operation was performed. There was no growth. The diverticulum could not be seen from the abdominal approach and there was, in fact, some doubt about the diagnosis of achalasia, particularly as her dysphagia did not remain long alleviated.

Over the six months prior to her admission to St. Alfege's with coronary thrombosis, the dysphagia had again worsened. She was a pale, thin lady with obvious recent weight loss. Her pulse was regular, of full volume, and her blood pressure 150/100. There was some enlargement of the left ventricle and she had at the apex a pan-systolic murmur, conducted to the axilla but no evidence of cardiac failure. Her chest was thin and resonant and well expanding but she had some basal crepitations and rhonchi. The abdomen was normal but for the laparotomy scar.





Investigations. Haemoglobin 9.8 gms. M.C.H.C. 29, W.C.C. 9,000, the red cells are hypochromic. Occult faecal blood strongly positive.

Chest X-ray.—There is a shadow of a dilated oesophagus seen to the right of the heart. The lung fields show pleural thickening at the bases and general emphysema.

The barium swallow is bizarre. The oesophagus itself is enormously dilated and contains a large quantity of fluid. To the right of the oesophagus and posteriorly in its lower third is an enormous diverticulum. The lower end of the oesophagus appears to be a benign stricture.

In view of her poor cardiac state it was deemed unwise to make a direct attack on the oesophagus but for her incapacitating dysphagia, a gastrostomy was performed on 5.11.64. The tube gave her some discomfort at first but she finally settled down and started to gain weight.

Diverticulae of the lower third of the oesophagus are uncommon, about twenty-six times less common than pharyngeal diverticulum, and are ascribed by all authorities to pulsive forces related to neuromuscular incoordinate movements of the wall. A poorly propagated incoordinate spasm, as in the analogy with colonic diverticulosis, might be expected to predispose to the development of a pouch at a site of deficiency of the muscle wall or where the wall has been weakened by inflammation. Especially might this be so in the presence of achalasia of the cardia, but the various authorities differ in their assessment of the incidence of diverticulum in this condition. Granet (3) in 1933 had collected from the world literature, forty-nine examples of true diverticulum of the lower oesophagus. Desseker (4) in 1924 had found five cases of diverticulum in only eight cases of achalasia. However, Johnstone (5) in 1949 had examined two hundred cases of achalasia without finding a diverticulum. Yet again in 1952, Goodman and Parnes (6) were suggesting that sixty-five per cent of diverticulae were associated with achalasia, but more recent studies suggest a less significant relationship . . . Habein 1956(7).

There is no doubt that the sigmoid dilitation of late achalasia may be confused with a large epiphrenic pouch (8) . . . Kaufman 1958. Moreover, oesophagoscopy is rarely helpful and often dangerous. As for the presentation it is generally agreed that although diverticulae may cause post-ictal distress, dysphagia and even nocturnal regurgitation, in fact dysphagia due to diverticulum alone is unusual.

The diverticulum usually extends anteriorly and to the right of the oesophagus and a further differential diagnosis must be made from an enterogenous or gastrogenous cyst communication with the oesophagus, or from a reduplication of the oesophagus.

In this case, final proof is lacking and the best evidence is radiological. The appearance of the cardia is that of achalasia and there is no doubt about the diverticulum! In this hospital a great deal of work has been contributed to the study of Achalasia (9). This case is offered as an additional point of interest.

(1) Barrett, N. R. (1964) i 1135-1140. Brit. Med. Journal.
(2) Franklin, R. H. et al. Brit. J. Surgery Vol. 50 1962-3 pp. 889.
(3) Granet. 1933. American Journal Surgery. XX 259.
(4) Dessecker, C. Das Epiphrenale Pulsions Divertikel der Speise Ohre. 1924. Arch. C. Klein Chir. 128, 236-247.
(5) Johnstone, A. S. 1949. Diverticulae of the Oesophagus. Brit. Journal. Radiol. 22, 413-422.
(6) Goodman, H. I. and Parnes, I. H. (1952). J. Thorac. Surg. 23.145.
(7) Habein, H. C. (1956) Arch. Surg. Chicago 72.1018.
(8) Kaufman, S. A. (1958). Amer. J. Dig. Dis. 3 38.
(9) Adams, C. W. M. et al. Guy's Hosp. Rep. 100.191.

I am obliged to Dr. W. Elliot for permission to quote this case, to Dr. B. Murray for the barium study, and to Mr. Hopewell at the Royal Free Hospital for details of their findings. The patient is at present under the care of Mr. W. R. O'Flynn.

A VOYAGE INTO THE PAST

John C. Dominick

On a bleak day with a Northerly wind some years before the 1914-18 War, I had the fortune and privilege to join a ship bound for Australia. She was one of the last ships in sail carrying a mixed cargo to Sydney New South Wales, and she would return to London round Cape Horn laden with wheat and wool in what was termed the grain race home.

In those days any young boy who had seen the tall ships come into "Falmouth for Orders" and gone on board those great sailing ships, both British and foreign, would have jumped at the chance of knowing more of the ships and those who made their profession the sea; it was the great adventure—it was messing about in ships on a grand scale.

As I was rolling down Rancliffe High Way
With a way, hay, ho, ho.
I met an old sailor just home from Hong Kong,
A long time ago.

She was a four-masted barque and lay in the South West India Dock in London. On this voyage she was fortunate to have as Commander a splendid man and a fine seaman. The officers were picked men and she had a number of Cadets, some of which had come from the training ship *Worcester*, then lying in the Thames, and some from the *Conway*, a training ship in the Mersey River. These lads were berthed in a deck-house amidships.

A hawser had been passed from a tug-boat and made fast to our own vessel in the dock, and another tug made fast as she gained the entrance to the dock. A motley crowd had come to see the ship pass into the river. Some were shouting, singing and dancing on the pier head and looked quite pleased to see her go. Some, however, were anxious mums.

Off Gravesend she anchored and the Cadets were divided into Port and Starboard watches, and sub-divided into gangs (serving the main and mizzen masts). Some quantity of Government explosives —cordite contained in 56 lb. cases—was loaded from the lighters, and the cadets developed healthy appetites with this rather laborious work done under a red flag twisted to the foremast, and two other red flags emblazoned with crowns in the rigging to indicate danger.

Down the Channel.

As a fair wind was blowing down the Channel, and the tide proper next morning, everyone was anxious to get away, so we passed with the tide. As the North Foreland was rounded, a small rowing boat hooked on to the vessel, towing alongside to Dover, where one of the pilots went ashore.

On September 7th, at 4.30 p.m., Beachy Head was abeam, and the tug was rewarded by a present of tobacco and a bottle of grog, and the line let go. We set all sail to a fair wind and as we sailed we saw the chalk cliffs of Beachy fade and grow indistinct in the haze. A good breeze sprang up and the good ship slipped along at eleven knots. As it had been arranged that those on board who came for the Channel trip should be put ashore with the pilot at Brixham, we stood into Torbay within a mile or so of Brixham. Some sails were braced aback and she lost way. A fishing smack came up with us and lowered a boat, and the Channel Pilot with the passengers were transferred to the smack. A hearty cheer was given and one returned. Then, the yards were traced about and we stood out to sea.

The beautiful Devon and Cornish coast remained with us in sight most of the day, and the last we saw of England that evening was the Lizard Light blinking around the sky.

"Macquarie"

Into the South Atlantic.

For about a week the light breezes and lovely weather enabled the watches to settle down, and the first voyagers were given instruction in the schoolroom and began to "learn their ropes", splicing, sail making and to place chafing gear. Numerous French fishing boats were passed with huge fishing gear sloping from the sides of their boats to the height of their masts. It was said they were fishing for porpoises. Some of them endeavoured to get close to us and ask if we wanted fish. After work in the evenings, lessons in signalling with flags and lamps were given to the young voyagers.

In the morning's work in the schoolroom a short Service was held daily among the Cadets, as is done in all H.M.'s ships. The Officers and some of the senior Cadets were members of the R.N.R., and much interest was shown about arms, drill, and other matters.

Now we are off Cape Finisterre—shades of George Borrow

and the ship he was in. At this time about a week out, the lovely weather was replaced by a slightly rough following sea. It made the vessel roll one night. This impressed upon the newcomers that life at sea was not "all beer and skittles." However, the grey seas and skies soon gave way to beautiful blue skies and fleecy clouds with shades of blue and light green water. In general, the birds disappeared, but a shore bird, one of a species of hawk which had lost its way, was seen. Vessels, too, became scarce, and one steamer signalled was probably too far off to distinguish the signals. Again on the 16th of the month a barquentine on the horizon was seen, but beyond noting she was going our way, nothing could be distinguished: she was out of sight next morning.

It is hot and getting hotter in the forehold, where the sails are stowed as the gangs bend the old sails and store the best for use in bad weather.

The lattitude of Gibraltar was passed on the night of the 16th October, Madeira on the 18th at noon, and Teneriffe on the night of the 20th October. On the 24th a ship, the *Invenarie,* was signalled with flags. She was out of Cardiff bound for the River Plate. Her Captain sent his love to ours and said he would report us on his arrival in port. The Cape Verde Islands were passed on the 26th. On the 27th October two swallows flew on board and settled on the swinging tray in the cabin. Many flying fish were seen.

Down to the Tropics.

As many reckoned on a fair wind down to the Tropics, disgust was shown with a head wind which impeded our way for days where the Trade Winds normally blow. Something seems to have gone wrong with the N.E. Trades. For some days the North West wind continued with a peculiar dry slightly misty weather, and a pungent smell of smouldering could be detected especially in the early morning. Some wondered about the explosives so laboriously put under the hatches at Gravesend. But it was suggested by those who know these things that it might be caused by the huge forest fires reported on the American main land. Vessels were occasionally seen and signalled. One steamer passed in the early morning made no reply to morse by lamps. Another passed within half-a-mile just between lights at dawn, but neither did she deign to notice us. On the morning of the 30th a ship was seen and recognised as one seen on the 16th, by her rig. She twisted her ensign. Probably she had no flags.

At this time, light, changeable, bafflingly fickle winds try the patience of the crew. Further, hauling yards around first one way and then another soon tires the watches, but now a severe thunderstorm is upon us which is fortunate, for one of the worst worries in sail is a lack of fresh water and every effort is made to save a supply from heaven. As it has been hot, and with the labour of working the ship, the luxury of a bath in rain water will be understood. What might have been a bad accident was averted when a Cadet

aloft developed a heat stroke. He was assisted to a "top" where he fainted and had to be lowered to the deck like a sack of flour.

When a man was signed on Ship's Articles for a voyage he was offered a month's advance note. Often he sold it to a "land shark" for much less than its value. The men consider they have worked for nothing in the first month. In the evening of the 4th October the men make a good effigy of a horse with old canvas and straw. They dress up, one as a jockey and so on and trail aft walking the old horse about the ship. The Bo'swain then addresses the Captain on the poop and speaks of the dim and distant past, sings a shanty and asks permission to dump the dead horse, praising the qualities of his steed. Permission having been given, the horse is twisted to the yard arm and set on fire. Then, let go with a run, it disappears in the wake astern. All hands grog ho! this is an old custom and can be impressive.

Blow for joy and blow for sorrow,
Blow boys blow.
A storm to-day and a calm to-morrow,
Blow my bully boys blow.

And now the ship goes bowling along with a good breeze at ten knots amid beautiful blue skies and seas. Encountered everywhere are flying fish scurrying about in shoals, while at night the stars shine bright and clear in dark blue skies all new and exciting to the first voyager. On first meeting the Trade Winds, the ship went considerably to the westward of her course, but now comes up to it by degrees and is bobbing about into a head wind. In fine weather bedding and clothes are strung out to air. By Captain's orders the rain water recently caught in the doldrums is used to wash dirty linen.

On October 6th we crossed the Equator to a very fair passage of 29 days. Some horse-play as Neptune's barber, doctor, and satellites do their work and duck the luckless first voyagers.

The ship's sports are held with the appearance of the "Old Firm." As most of the races are obstacle races, the Firm is in pocket and the Cadets are stiff and sore next day.

And the next day was what is known as Shadowless Man Day, as the sun being immediately overhead at noon, cast no shadow. The young lad who had been reported suffering from heat stroke now had another attack. Luckily he was on deck [it is interesting to remember that in the days of Queen Victoria and Kipling's India, great respect was given to the sun.]

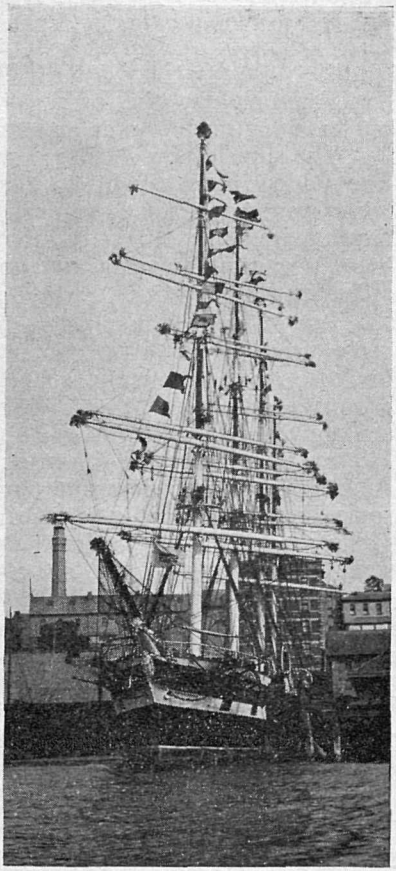
As we sailed leisurely through the water, a large fin was seen close to the vessel. The cry of "shark" went up. A thrill of excitement goes through the oldest as well as the youngest seafarer at the sight of their enemy; one rushes to the cook for salt pork; another goes for a hook and line, and someone goes aloft to keep the enemy

under observation. However, on this occasion, the shark sheers off —not interested in salt pork. Some time later a big shark was caught and some difficulty found in getting it inboard. This accomplished, a great stink goes up and settles in the berth amidships—it haunts the tropic night as the watch goes the rounds trimming yards.

About this time heavy rain comes down and all are sodden and subdued, but the tanks are filled and as the rain clears off we get a view of some water spouts around the ship.

In these latitudes under the watchful eye of the Scots First Officer, voyagers take it in turn at the wheel and found it by no means easy to make a straight wake or to hold a wilful ship on her course by watching the clew of a royal without a look at the compass card. One miserable youth got the ship aback and woke the watch below.

A little cat brought on board in London has caught her first mouse and brings it with pride to the Cadets' schoolroom for approval. On October 15th those aloft saw a large bird bearing down on them with menace, or so it seemed, but it sheered off in a lovely movement. This bird, the albatross, is a thing of great beauty. By this time we are out of the tropics and as the moon was growing larger and the weather fine, beautiful moonlight effects were to be seen. On one occasion a lunar rainbow.



"Port Jackson".

Into the North Atlantic.

On leaving the tropics, the colour of the water changes to a more steely blue and the days grow cold. Misty weather comes on and the bray of the mechanical fog horn operated on the forecastle head makes a mournful noise and creepy feeling as the ship glides through the water and extra look-outs are posted and creaking gear aloft with swirling fog gives a thoughtful unease to the mind which is not altogether dispelled by the half-hourly cry from the forecastle head of "All's Well." A hoarse croak close to the ship makes the uninitiated start.

Some interest is caused by a rumour that we may sight the volcanic island of Tristan da Cunha in the South Atlantic in the latitude of the Cape of Good Hope. [It may be remembered that after the 1914-18 war a great foreign barque disappeared without trace with a large number of Cadets and crew in these gloomy waters.] The fog is now clearing and the weather damp and clammy, just the sort of weather in England at this date, October 29th.

Easting Down.

For some days the fog goes off and then down, very thick, without headway made by the ship. Fog horn keeps us awake.

The ship is now 43 degrees south and our course is now East. The Cadets have caught an albatross—a splendid bird of 10 feet wing span; as it stood on deck it appeared to look at us with a haughty tragic air. To-day more albatrosses have been caught and there is a great scraping and boiling up—the berth stinks of these activities.

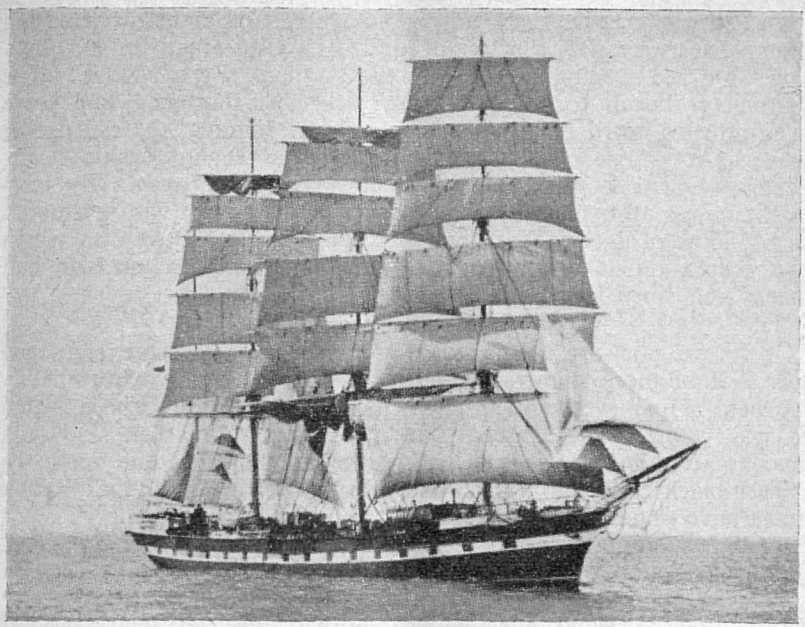
But at last the barometer shows signs of change and a breeze comes from the right direction. The walk of the officers and men becomes more sprightly. When a bright sunshiney day comes, advantage is taken of it and clothes and bedding are aired. The days are drawing out and there is a smell of Spring in the air. November 1st saw a most beautiful sunset; masses of cloud came up astern. A very red sunrise next morning—not the shepherd's delight—with some dirty drizzle and greasy sea. The birds begin to fly high in an excited manner surely indicative of bad weather, but we are soon snug under shortened sail, although seas come lapping over the rail and flood the allay ways and main deck and there is a stiff breeze.

Shortly after noon on the 4th, some of the birds were seen sitting on the water, and the experienced knew that it was all over. At 3.30 the temperature was only 48 degrees in the Cadets' berth. The inhabitants of the forecastle were well muffled up. In the evening the thermometer fell to 43 degrees and the shrivelled appearance of one of the Cadets led one of those in the watch below to remark: "Oh, wert thou in the cauld blast?"

November 6th—South Easterly head wind with steel grey clouds and the cold rain which accompanies Easterly wind anywhere. Many birds seen flying low but quickly as if to keep themselves warm.

On the 9th November the water changed colours. We went past the Crozet Islands, another milestone on our journey. A Westerly wind came on and the decks were flooded and the old ship made her 12 knots. Next day it was found she had made a record run for the passage, 306 nautical miles or 344 statute miles. Great rejoicing was cut short as the breeze hauled to the Southward and died away in the afternoon as it generally does.

The next day was a beautifully warm and sunny day in which everything aired and dried. Sea birds seen, the tiny ice birds and the stormy petrel so called Mother Carey's chicks, whose feet patter on the water as the Apostle Peter walked. The next day the weather



"Port Jackson".

is calm for these latitudes, and in the evening the very bright and beautiful moon looks so near, but it is the only thing seen by the first voyager that is not strange—nothing but water. As we sailed in a moderate breeze, a steamer's smoke was seen, a rare sight in this locality. She overtook us at 2 p.m. on 17th November and proved to be the *Port Chalmers* bound from the Cape to Adelaide. The steamer made a brave show on a lonely sea as she sucked and lifted and showed her rusty hull. Her passengers lined her rail and appeared to be taking pictures. She promised to report us. Wished us luck and gave a cheer and went ahead. We were sad to see her go.

The Great Australian Bight.

On the evening of the 19th the wind suddenly dropped. We were bowling along at 13 knots at 7.45 p.m. At 8 p.m. the speed was reduced to two knots; that was not enough to keep her steady. A first voyager gave it as his opinion that she might "roll the sticks out of her." As a Senior Cadet heard this remark it proved unwise.

Rarely does a stormy petrel come on board a ship, but the cat caught one and played with it until it was taken away from her. That night the Aurora Australis or Southern Lights was seen in the Southern sky. It is generally considered they are a harbinger of a strong blow. A heavy gale and high seas were encountered on the 22nd November. A comber flooded the saloon aft and the Cadets' berth was flooded on the 23rd November. Next day was finer and we concluded we were going North of Tasmania and through Bass Straits.

Every effort was made to get the ship in order before reaching port. Masts scraped, rust removed, brass scrubbed up for a polishing. On the evening of the 26th the sky had a greasy look. The barometer began to fall ominously, sail was shortened and there was little on her! As a high cross sea was running, the old packet gave us a sample of her rolling powers and began to ship heavy water. Everyone wondered where it was coming from. By midnight it was all over and we sailed in a light breeze with a smooth sea. Some of us saw that night the light on Cape Otway, to which we steered and land was seen. Many were excited as no land had been seen since Falmouth and the Lizard Light.

Man Overboard.

As we came up to the signal station at Otway, there happened just one of those things—a young lad fell overboard. Fortunately he held a line overboard. Then, the Second Officer, whose watch it was below, went overboard in a bowline, to help the lad, and encouraged him. After some effort they were got to the deck, the officer black and blue and the lad full of water. The Signal Station must have wondered at the strange manoeuvring of our ship.

A few hours later a British Man o' War passed a long way off, no doubt bound for Sydney.

She fired a gun and she made a racket,
Blow, boys, blow.
Oh make some way for a deep sea packet,
Blow, my bully boys, blow.

The next day we signalled Wilson's Promontory and some chronometer errors were verified.

Just at this time the little cat caught its first rat and took it proudly to show its friends. That evening she was missing. A hue and cry was raised—but the little cat was not seen again.

In the Tasman Sea.

The weather was now glorious. A bright warm sun shone in a cloudless sky. Beautiful nautili called by sailors "Portuguese Men of War", drifted past.

A light was seen at 4 a.m. on November 6th blinking away in the West, and made out to be Perpendicular Head about 80 miles from Sydney.

The smoke of a steamer was seen and increased until one of the clan "turret" steamers passed bound for Melbourne. A few hours after more smoke appeared on the bow, which proved to be the tug *Hervia,* which came alongside and gave us the news. She took us in tow and soon brought us out of the current running down the coast. The Pilot boarded us off Sydney Heads at 6 p.m. Numerous officials came on board and inspected us to see there was no sickness on board. We proceeded to Rose Bay and anchored until the Government explosives had been discharged.

The next morning a young lad on anchor watch duty saw the decks covered with dew in the first clear spring light of dawn. As the sun came up, the fair city of Sydney was before him clothed in colours of lavender and rose. What more could a young first voyager want after 90 days at sea?

CORRESPONDENCE

On Mac Keith's Phenomenon

SIR,—As Ronnie Mac Keith will realize, since he is kind enough to quote our heated discussions repeatedly, his stimulating contribution to your August issue on the automatic motor behaviour of infants is a challenge I cannot refrain from taking up.

Putting dogmatic time limits to the automatic responses which are said to appear and disappear is certainly oversimplifying, as Mac Keith rightly points out. The reason for this criticism is not just the fact he quotes that these reactions may be found at different ages in different children, but, I think, a more fundamental one: that the development of static function has to be seen as a dynamic structuration of patterns which interact on each other, building up that particular combination which is needed at each functional milestone.

From a semeiotic point of view, we are interested in certain responses, not for the consistency of a finding with a statistical mean, that is as isolated items of a developmental scale, as Mac Keith seems to suggest, but because of their action as part of a functional achievement. This occurs during part of the period in which they may be elicited, when their strength allows them to emerge from the diadicasia (diadikasia=fight for precedence) and effectively mark with their pattern the forthcoming function. The importance of a finding is therefore relative to the functional condition tested and a rating in itself is meaningless.

As regards the Placing Reaction (correct Italian spelling: reazione d'appoggio), teleologically related to static function, it seems to be more probable when the other neonatal reflex static achievements are also in action. Therefore it is unfortunate that Mac Keith divides the observations into three periods which bear no relation to the developmental phases of the static function. It would have been interesting to correlate this reflex behaviour with the others, isolating the observations of the 3rd-4th month, since placing is the negative image of the well-known abasia which appears during the astasia following the primitive supporting reactions.

The original contribution of what may be called Mac Keith's phenomenon is an interesting example of this complex dynamic interaction.

To question 1: As primary walking is more evident in " slightly excited children" (Stirnimann cited by Peiper), the aspecific disagreeable stimulation of Mac Keith's index fingers as appears in the photograph, may be relevant; but the extensor synergic stimulation is in my opinion the most important factor.

Passive or active extension act in the same way because the proprioceptive afferences from muscle spindles and possibly from articular receptors convey position information regardless of the force applied. And why should Mac Keith understand this phenomenon when it is demonstrated by a pretty therapist and not when I tell him?

It is difficult to answer Mac Keith's second question, but my impression is that the occasional flexion observed corresponds to a negative supporting reaction due to unintentional suspension of the child, because of the inability of the examiner to follow the vertical oscillations when stepping is particularly well marked.

As Mac Keith quotes correctly, I do not think that the symmetric tonic neck reflex has anything to do with this phenomenon because even later when at five months the child seems to " look up at the table" supporting the trunk on his extended arms, hip flexion does not occur. The symmetric tonic neck reflex complete pattern appears at the age of six months when hip flexion allows the child to get into 4-foot kneeling.

The two questions in the last two lines of Mac Keith's paper suggest hypothesis which appear to me to be a bit far fetched.

Yours, etc.,

ADRIANO MILANI COMPARETTI.

Centro di Educazione Motoria,
" Anna Torrigiani,"
Via di Camerata, 8,
Firenze.

The Pending Retirement of Sister Perkins

SIR,—The news of the pending retirement of Sister A. L. Perkins in October, has been widely known for many months.

Sister Perkins came to Guy's in February, 1928, and was appointed Sister in 1932. She held a variety of Sister's appointments and also those of Night Superintendent and Assistant Matron, before leaving Guy's in 1948. During the following ten years, Sister held the post of Matron of The City Hospital, Sheffield, for two years, and of District Nurse/Midwife and Health Visitor in Cornwall for eight. She returned to Guy's to the appointment of Senior Assistant Matron in April, 1958.

Sister Perkins' retirement brings the departure of one of the most faithful daughters of Guy's: one who has never doubted that the glories of yesterday will be vigorously translated into the needs of the National Health Service to-day, and into the still wider dimensions of to-morrow's commitments; and one whose devotion to the Guy's Family surpasses all comment.

I have obtained a suitable leather-bound book, in which those who would wish to be connected with a farewell gesture to Sister Perkins may sign their names, and leave a donation in the Matron's Office. I will divide the book into three sections—

Nursing Staff, Past and Present.
Medical Staff, Past and Present.
All Other Friends.

In order that those who are abroad may not feel dissociated from this arrangement, I will welcome their signatures on suitable pieces of paper which will be affixed into the book accordingly. Cheques should be made payable to Guy's Hospital, and receipts will, of course, be despatched without delay.

This opportunity will remain available until 31st December next.

Yours, etc.,

ANNE M. JOHNSON,
Matron, Guy's Hospital.

Matron's Office,
Guy's Hospital, London, S.E.1.

Guy's Hospital Nurses' League

SIR,—The Biennial Cocktail Party will take place on Saturday, 9th October, 6 o'clock—8 o'clock, in the Nurses' Home.

A few tickets (price 7s. 6d.) remain available from Matron's Office.

Yours, etc.,

ANNE M. JOHNSON,
Matron and Honorary Secretary.
Guy's Hospital Nurses' League.

Matron's Office,
Guy's Hospital, London, S.E.1.

Guy's Hospital Dental Society Annual Ball

SIR,—The Guy's Hospital Dental Society Annual Ball will be held on Friday, 5th November, 1965, at the Europa Hotel, Grosvenor Square. Tickets will be available after September 28th, from Stuart Orton-Jones or David Lewin.

Yours, etc.,

STUART ORTON-JONES,
Dental Ball Secretary.

The Dental Department,
Guy's Hospital, S.E.1.

The Work of the Child Welfare Clinics

SIR,—In the recent article "The Work of the Child Welfare Clinics" which appeared in the *Gazette* dated the 4th September, 1965, I was surprised to see no mention of the important part the Health Visitor can play in the prevention of dental disease. The appalling dental condition of so many young children emphasises the importance of preventive dentistry since, on grounds both of cost and dental manpower, it is impossible to cope with the ravages of dental caries by reparative means.

The Health Visitor in her association with expectant and nursing mothers has a unique opportunity to stress the importance of maintaining the mother's own dental health and of safeguarding the infant's dental health through correct diet, oral hygiene and regular visits to the dentist from the age of about two years.

In this Authority where more often than not there is a dental surgery in the welfare clinic, the dental staff is encouraged to work in the closest co-operation with Health Visitors and Clinic Nurses to ensure that advice on dental matters, and treatment if necessary, is freely available to mothers and young children.

Yours, etc.,

J. C. TIMMIS,
Principal County School Dental Officer.

Staffordshire County Council,
Health Department,
County Buildings,
Stafford.

SIR,—On page 414 of your issue of the 4th September, there is an article on "Child Welfare Clinics" by Miss G. Saint, Superintendent of the Salomons Centre; and in your editorial you remind your readers that the Centre was founded by Cameron and was part of Guy's. However, after the passing of the Health Act, the Centre had by law to be handed over to the local authority, to wit the L.C.C. That body proved accommodating, and after negotiations, in which the Medical School of Guy's played a valuable part, an effectual compromise was reached. The reign of the L.C.C. is now over; what is the future of the Centre?

Mr. Burfoot in his account of the future of Guy's gave no information on this subject. Miss Saint offers her views on the way in which a Welfare Centre ought to be run and its purpose, but the existence of Guy's could scarcely be inferred from what she says: it is on a Medical Officer of Health that a Centre is based according to her notion. Yet there were minds in Guy's who thought that the place was valuable for teaching and worth preserving; and mine is as theirs. What will become of it when the obstetricians move to their new abode? What will be the fate of Infant Welfare in the hospital of Cameron, who largely inspired the movement?

Yours, etc.,

H. ST.H. VERTUE.

LARCH TREE LODGE,
37, TOWER ROAD,
ORPINGTON, KENT.

Photographic Society

SIR,—In spite of the large membership, the meeting was so poorly attended that it has not been possible to assess general interest in a summer exhibition. I should be most grateful if members wishing to exhibit prints in late October, would leave notes for me in the Photographic Society pigeon hole within a week.

Yours, etc.,

LYALL RIKARD BELL (Hon. Sec.)

Guy's Hospital,
London, S.E.1.

FAST DEEP SURE and DESIGNED FOR THE JOB

XYLOTOX DENTAL ANAESTHETICS

are essentially different, in that they are specifically devised to meet the specialised needs of the dental surgeon; they do not represent a compromise between medical and dental requirements. That is why Xylotox remains today the local anaesthetic used by 70 to 80 per cent of British dental practices and is exported to between 80 and 90 countries throughout the world.

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REVIEWS

CLINICAL PHONOCARDIOGRAPHY

Dennis C. Deuchar, M.D., M.R.C.P. English Universities Press Ltd.

This is one of the first two books to be issued in a new series of Modern Medicine. Dr. Deuchar has set a very high standard for those authors who are to follow him.

In the last twenty years the significance of the auditory cardiac signs—well described in the last century—have been clarified by the advent of phonocardiography, at the same time as the knowledge of function in health and disease has steadily increased with modern methods of investigation, first started by cardiac catheterisation. Over the same period, cardiac surgery has made accurate anatomical diagnosis imperative and in this the stethoscope, and a trained ear attached to it, play a major part. The graphic registration of the auscultatory signs—phonocardiography— is valuable in training the ear, to discipline and verify the trained ear, and to augment haemodynamic studies in diagnosis and assessment of severity of acquired and congenital lesions which may need surgical treatment. The ability to measure phenomena factually may in itself be sufficient to augment the clinical examination and to obviate the need for more complicated and haemodynamic investigations.

The author has covered his field in 135 pages with such clarity and succinctness that this reviewer can make the honest, if rare, claim that he has read every page, and with pleasure. For a complicated and technical subject with its own terminology the text reads remarkably easily, with cross references to avoid repetition and a wealth of illustrations to clarify all the points made. Line drawings have wisely been chosen to show haemodynamic events which determine the auditory signs, though examples of phonocardiograms themselves are also shown.

As its title indicates, the object of this book is to demonstrate the clinical value of phonocardiography, and in this it succeeds admirably. For the student, what is accepted is skilfully distinguished from what is still controversial, and he will find it a stimulus to apply his stethoscope intelligently and usefully to the patient. The practitioner or consultant who is still a student would find it an admirable and quick way to revise his concepts and perfect his skill in the diagnosis and assessment of heart lesions and to assimilate the advance of knowledge in diseases of the valves and congenital heart lesions.

This book is well produced and very good value for twenty-five shillings.

C. G. BAKER

A SHORT TEXTBOOK OF SURGERY,

Eighth Edition. 65 *shillings*. By Sir Charles Illingworth, C.B.E., M.D., Ch.M., F.R.C.O. (Ed. and Glasgow).

As the Final Surgery Examination approaches, every student wishes that a *really* short textbook of surgery were available! Sir Charles Illingworth's book is shorter than most surgical textbooks, but is still a large book by any standards. The book is clearly laid out and, of course, very well written. There are many excellent photographs and X-rays (those of the G.U. Tract being really outstanding). This is an essentially practical book and the emphasis is laid on the investigation, diagnosis and treatment of *common* conditions. The sections on infections of the hand, skin grafting, fractures, the diagnosis of breast tumours, and the technique of tracheostomy are good examples of this practical approach. The reader is not drowned in detail or in the description of the very rare disease, but the common congenital lesions are well covered. The diagrams are not up to the high standards of the rest of the book. Many of them look out of date and there are few " diagrammatic " diagrams and charts which can impart in a small space as much information as many pages of prose: and with much less effort needed on the part of the reader. With this one reservation, this book goes a long way to fulfilling the needs of those upon whom the Final Exam. is coming uncomfortably close.

JOHN CRISP.

SPORT

RUGBY FOOTBALL

The 122nd season of Guy's Hospital Rugby Football Club, started with the traditional game against Bromley, formerly Catford Bridge. Guy's rattled up sixteen points in the first half, but a very heavy shower early in the second slowed the game down considerably, and we were able to score just one more try, to win 19—0. The game is reported more fully later.

Serious training started six weeks ago and has been very well supported. Over the first week-end in September, twenty-two people went down to "Thatchings" for some concentrated training, some fresh air and good victuals from Mr. Lewis, the caretaker. We arrived down on Friday afternoon, and started with a gentle session. Two strenuous sessions on Saturday, Sunday and Monday followed, and everyone returned with the feeling that the week-end had been of great benefit.

Everyone was put to the test on Wednesday, when John Davies, the captain, arranged a very friendly game with St. Mary's, for the express purpose of getting match practice and sorting out the team before the season started. The game took the form of three twenty-five minute " halves ", and thoroughly fulfilled its purpose. The game was played in the friendliest spirit and the score is unrecorded.

FIRST FIFTEEN

Date 1965	Opponents	
Sept. 11.	—Bromley	H
,, 18.	—Blackheath	H
,, 25.	—Old Askeans	H
Oct. 2.	—United Services Portsmouth	A
,, 9.	—Cambridge University	A
,, 16.	—Bedford	A
,, 23.	—Cheltenham	A
,, 30.	—Cambridge R.F.C.	A
Nov. 3.	—University of London	H
,, 6.	—Old Blues	H
,, 13.	—	
,, 20.	—Metropolitan Police	A
,, 27.	—Stratford	A
Dec. 4.	—Streatham-Croydon	A
,, 8.	—Buckinghamshire County R.F.C.	A
,, 11.	—Old Cranleighians	A
,, 18.	—Esher	H
1966		
Jan. 1.	—Richmond	H
,, 8.	—Plymouth Albion	A
,, 15.	—Taunton (11 a.m.)	H
,, 22.	—Devonport Services	H
,, 29.	—Old Millhillians	A
Feb. 5.	—Coventry	H
,, 12.	—Oxford R.F.C. (11 a.m.)	H
,, 19.	—London Irish	A
,, 26.	—Exeter	A
Mar. 5.	—Old Alleynians	A
,, 12.	—Nuneaton	A
,, 19.	—Gloucester	H
,, 26.	—	
Apr. 2.	—Old Whitgiftians	H

"A" FIFTEEN

Date 1965	Opponents	
Sept. 11.	—Bromley "A"	H
,, 18.	—Blackheathens	A
,, 25.	—Aylesford Paper Mills	H
Oct. 2.	—U.S. Portsmouth Buccaneers	H
,, 9.	—	
,, 16.	—Bedford Wanderers	A
,, 23.	—London Irish Wild Geese	H
,, 30.	—Beckenham "A"	H
Nov. 6.	—Old Blues "A"	A
,, 13.	—Old Askeans "A"	A
,, 20.	—Rosslyn Park Stags	H
,, 27.	—Old Rutlishians "A"	H
Dec. 4.	—Old Millhillians "A"	H
,, 11.	—Lewes 1st	H
1966		
Jan. 1.	—Streatham-Croydon Serpents	H
,, 8.	—Shelford 1st	H
,, 15.	—ENGLAND v. WALES	
,, 22.	—	
,, 29.	—Wimbledon 1st	A
Feb. 5.	—Coventry "A"	A
,, 12.	—ENGLAND v. IRELAND	
,, 19.	—U.C.S. Old Boys "A"	H
,, 26.	—Metropolitan Police "A"	H
Mar. 5.	—Old Alleynians "A"	H
,, 12.	—Nuneaton Ex. 1st	A
,, 26.	—Esher Abbots	A
Apr. 2.	—Old Whitgiftians "A"	A

KICK OFF TIMES

September, October, March, April, 3.00 p.m.; November, February, 2.45 p.m.; December, January, 2.30 p.m.

REPORTS AND RESULTS

GUY'S v. BROMLEY

At H.O.P. 11th September, 1965

Result: won 19—0

Guy's enter their 122nd season with a large selection of forwards, but until later, anyway, only a small number of possible backs. This is always a favourable balance and should serve the Club well. John Davies has a wise enthusiasm for the game and will without doubt give the fifteen sound direction and example. Morris is still available at full-back, and Edgar, re-elected Vice-Captain, will give useful experience in the centre. Ross, given the opportunity, will outstrip many a defence, and Rowlands, at fly-half, has a sound pair of hands and is fast developing a varied range of moves. These players at their best pick themselves, the other back positions are open to competition. For all the positions in the pack there are two or more players with 1st XV

experience. In addition, Thorburn, an Oxford blue, at the moment touring in the Argentine, would seem likely to gain a place in the back-row. For the selectors, this is a healthy position, and for the players one of continued trial. Injuries and lapses of performance will help sort things out, and those who find themselves in the "A" XV will have worthy companions.

The first game of the season is always difficult to review for inevitably match conditions create factors which cannot be prepared for in practice, and which make moves difficult to initiate and complete. One expects to see, however, enthusiasm, fitness, basic skills, and sound tactics. None of these were lacking in the Hospital's performance—a compliment to pre-season preparations. The forwards in the first half hunted the ball with obvious determination and the manner in which hands were seen scooping up the loose ball showed that this important essential has been appreciated from the start. The rucking for the most part was solid, but tailed off in the second half when too many participants stood on the fringes. The tight scrummaging appeared well-knit, and Lewis gained the larger share of the ball. The tap-back was the choice for line-out play, and whilst this worked early on. Davies sensibly had the ball brought down to him as a double-banker in the wetter second half. Williams, Sharp, and Brown showed up ubiquitously. Moore, at scrum-half, got the ball away quickly to Rowlands—not until late in the second half did he fail to look before passing, with subsequent inaccuracy. Rowlands had several moves up his sleeve, but at times tended to overrun with the ball, being either caught in possession or allowing his centres the same fate. In the threequarters, strong running was mixed with rushed passes and several chances were missed in this way. Often, as well, after unsuccessful breaks, the centres gallantly tried to keep the ball in play, but with backward flicks which were too powerful to be taken by anyone following up at speed. Most of the successful attacking came from combined running of backs and forwards from possession in the loose. The fifteen were rarely tested in defence, and when under pressure had time to cover-up adequately.

Guy's pressure in the drier first half was unrelenting and the first score came when Rowlands took the ball on the blindside, beat a man, and passed on to Ross, who raced over shaking off several defenders. Edgar failed with the conversion, but followed this with a successful penalty kick from 30 yards. A long throw in a line-out allowed Moore to break through with Kingdon up inside. He passed on to Davies, who romped over. Edgar converted well. Just before half-time, Rowlands put through a well-placed grubber which Edgar dribbled over. Morris converted.

Heavy rain in the second half made handling difficult and called for a change of tactics. Moore and Rowlands took play up the field using the touchline and continued pressure in the Bromley half paid off when Brown went through from a line-out for an unconverted try.

Overall, the performance was satisfactory and the scores came from good movements. In between times, however, there were several mistakes in handling which against a stronger side would result in lost ground as well as valuably missed chances. In general, however, things look well for John Davies and the Club.

Team: A. Morris; J. Ross, R. Beecham, J. A. Edgar, D. Fleming-Jones; B. Rowlands, B. Moore; J. E. Davies (Capt.), C. Lewis, R. Stansfield; P. Peace, A. Kingdon, H. Sharp, K. Brown, P. Williams.

I. A. BAKER

TENNIS

The Tennis Club has had its most successful season for many years, culminating in victory in the Inter-Hospitals Cup against St. Mary's.

In all, the 1st VI played 24 matches, winning 20, and losing to Imperial College, 4—5; Lloyds Bank, 3½—5½; Shooters Hill, 3—6; and West Hants Lawn Tennis Club, 27. We were undefeated in Hospital friendlies, thrashed St. John's and Queen's Colleges, Cambridge, and had two easy victories in evening matches over R.N. College, Greenwich. For the first time for at least five years, we beat Winchester, and beat them handsomely 7—2. We also beat Westminster Bank, Midland Bank twice, and Lloyds Bank on our own courts.

In the Cup, we had a bye in the 1st round, and beat the London 6—3 in the 2nd round in appalling weather conditions. The semi-final against Bart's was interrupted by rain, and we had to return to their ground the following evening to finish the match. After leading 4—2 the first evening, we won the remaining three matches to win the tie 7—2.

On 30th August we met Mary's—the holders—in the final. Their team comprised three very good players, including a former Welsh Junior Champion, and two regular United Hospitals players, but a weak 3rd pair. The Guy's team was John Hopkins, junior Kent player, and J. Newman, C. Newman, the Captain, and R. Machell, P. Swiss and H. Sharp.

In the 1st round, our 1st and 2nd pairs beat the Mary's 2nd and 3rd pairs; our 3rd pair salvaged a set from the Mary's 1st pair. Thus we led 2—1. In the vital 2nd round, respective pairs met, and the 1st pairs produced a game of exceptional Hospital standard. Right from the start, Hopkins and Newman took command, much to the annoyance of the Welsh International, who found his "winners" returned with interest in the first few hard fought games, after which he lost interest, and Guy's, maintaining the pressure, ran out 6—1, 6—1, winners. The 2nd and 3rd pairs both won in straight sets, and thus Guy's gained a winning 5—1 lead to wrest the cup from Mary's. Guy's have now won the cup from 1951-59, 1961, 1963, and 1965—a grand record.

The second side, although short on fixtures, had a successful season, under the captaincy of J. H. W. Davies. J. Siegle, another member, has often played in the 1st VI, partnering either R. Knight, in his Victorian outfit, or J. Davies—the latter being notable for his powerful smashing at the net—alas! the ball having long since passed.

In retrospect, the season has been most enjoyable, amusing, and the tennis of a high standard. This augers well for next season, for only C. Newman, the Captain, is leaving.

H. C. SHARP

Hospitals Cup Final

GUY'S v. ST. MARY'S

At. H.O.P. 30th August, 1965

	1st	2nd	3rd
J. Hopkins	6—1	6—2	
J. Newman	6—1	6—4	
C. Newman		7—5	6—1
R. Machell		6—4	6—3
P. Swiss	3—6		6—1
H. Sharp	6—4		6—3
	2—6		

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Senior Registrar in the Paediatrics Department** with duties commencing mid-October, and appointment until 30th September, 1966, in the first instance. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, London, S.E.1, not later than **24th September, 1965.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Senior Registrar in Diagnostic Radiology,** with duties to commence on 1st December, 1965, and appointment until 30th September, 1966, in the first instance. Applicants should hold the D.M.R.D. A higher medical or surgical qualification would be an advantage. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, not later than **24th September, 1965.**

GUY'S HOSPITAL AND SOUTH-EAST METROPOLITAN REGIONAL HOSPITAL BOARD

Applications are invited to fill an established vacancy for the appointment of **Senior Registrar in Physical Medicine to the Board of Governors of Guy's Hospital and the South-East Metropolitan Regional Hospital Board.** The appointment will be from 1st November, 1965, to 30th September, 1968. Applicants will be expected to spend the period 1st November, 1965, to 30th September, 1967, in Regional Board Hospitals of the Bromley, Sevenoaks, and Orpington Group. The appointment will be made jointly by the bodies concerned. The post, which will be reviewed annually, is subject to the Terms and Conditions of Service of Hospital Medical and Dental Staff (England and Wales) with duties commencing 1st November, 1965, or as soon after as possible. Forms of application are obtainable from, and should be lodged with the Superintendent, Guy's Hospital, S.E.1, not later than **30th September, 1965.**

GUY'S HOSPITAL, LONDON, S.E.1.

Applications are invited for the post of **Registrar in General Medicine**, with duties commencing as soon as possible, and appointment for one year in the first instance. Application forms are available from, and should be returned to, The Superintendent, Guy's Hospital, London, S.E.1, not later than **25th September, 1965.**

GUY'S-MAUDSLEY NEUROSURGICAL UNIT

Applications are invited for the post of **Registrar** (Middle grade) for one year commencing 1st October, 1965, or as soon as possible thereafter. The Unit, which is housed in the Maudsley Hospital, serves both Guy's Hospital and the Bethlem Royal, and Maudsley Hospitals. Applications should be made by the **24th September, 1965,** to L. H. W. Paine, House Governor and Secretary, Maudsley Hospital, Denmark Hill, London, S.E.5.

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Registrar in Radiotherapy** from 1st October, 1965, for one year in the first instance. Forms of application are obtainable from the Superintendent, Guy's Hospital, S.E.1, and should be returned to him not later than **24th September, 1965.**

GUY'S HOSPITAL MEDICAL SCHOOL

Applications are invited for a post of **Lecturer in the Department of Anatomy,** with duties to commence as soon as possible. Salary in the scale of £1,805 to £2,505, plus £60 London Allowance with superannuation. Forms of application are obtainable from, and should be lodged with, the Dean, Guy's Hospital Medical School, London Bridge, S.E.1, before **30th September, 1965.**

PERSONAL

Guy's dental surgeon in urgent need of Associate, with possible view to partnership. Family practice in still expanding area of North-West Middlesex, adjacent to green belt. Principal wishing to increase his hospital commitments. Box No. 31.

Doctor at present working part-time at Guy's requires afternoon and/or evening surgeries in London area. Available immediately. Reply Box No. 32.

Blackheath, furnished flat, large lounge, bedroom, kitchen, fridge, bath and lavatory, newly decorated, 2 adults. Apply Box No. 33.

Two Guy's men in coastal town near Brighton would welcome a third as an assistant or associate; a good opportunity to learn how to run your own practice, plus sailing, golf, shooting, etc. Own laboratory and very nice people to work on. Accommodation available; Ideal for newly qualified or qualifying man. Reverse charges and telephone Newhaven 406, Brighton 51550, or Seaford 4902.

East Sussex Coast—Assistant required January, 1966, with definite view to a permanent Associateship. Modern premises and superb surgery with all new equipment. Every type of work available. Hygienist and first-class staff, including large Laboratory. Genuine opportunity for young man wishing to settle. Enquiries welcomed from students qualifying this Christmas. Box No. 34.

CHANGE OF ADDRESS

Dr. and Mrs. M. Hardman (née MacGregor), 121, Broomfield Avenue, Worthing, Sussex.

Mr. Michael Maberley, B.D.S., L.D.S., R.C.S., to 20, Aralia Drive, Mona Heights, Kingston 6, Jamaica, W.1.

BIRTHS

HORNER.—On 27th July, 1965, to Beryl Jane (née Honeyban) and Dr. Adam Horner, of Covscombe, Nr. Dorchester, twin daughters (Jane and Joanna), sisters for Simon.

WILSON.—To Irene (née Wallace) and Derek Wilson, at Hereford County Hospital, on 26th July, 1965, a son, Timothy Huw, a brother for Louise.

DEATHS

HODGSON.—William Archer, L.D.S., late of 108, Harley Street, died quietly on the 18th July, 1965, in Kingston Hospital, aged 78.

EDITORS P. BOWDEN AND A. E. RAYNES
SPORTS CORRESPONDENT A. PROCTER
FORTNIGHTLY TWO SHILLINGS VOLUME 79 NUMBER 2013

PASSIM

Dissent is in the Air

The incongruous silence of the junior staff at teaching hospitals has at last been broken and at one such institution these doctors have spoken out to claim pride of place as the poorest relation in the medical family. Elsewhere their complaints are probably shared but not their audacity for any action is considered to be fraught with risk, criticism may be interpreted as relating specifically to a hospital or the method therein and the rebel is haunted by the delusional tut-tuts of his sages. The weight of tradition is heavy on his shoulders and he knows full well that his forebears paid to hold the privileged position that he is finding too demanding, he knows, too, that there are many who would gladly accept all the burden of which he is trying to relinquish a part. Perhaps he feels that if he speaks, the chances of obtaining a good post, and thereby the key to his future, are weighed heavily against him. If the general practitioner has cause for complaint, so does junior staff in hospitals and their plight should be openly discussed and equally publicised or those outside the profession will be ignorant of their plight and will fail to realise the full extent of the reform needed in this field.

In 1953, a year's residence became compulsory before the newly-qualified could become fully registered and so practise medicine, and he probably learns more in this time than in any other year of his life, it is an extension of his studentship. He should, however, be treated humanely, he should be able to take time off duty without having to canvass for a stand-in, salary increments should not be cancelled by increased deductions from his paltry pay, the list is long and it would be invidious to continue. Only the ambitious or the foolhardy put up with it any longer than they have to.

Discrimination has, however, been exercised in respect of the Armed Forces, for they are able to offer "outstanding opportunities, good pay, good allowances, six weeks' annual leave with reliefs provided, and a furnished house at low rent for married practitioners, and a tax-free gratuity of several thousand pounds". It is surely morally unjust for the State to provide doctors in the Forces with remuneration and facilities which it denies to the National Health Service. The Services are able to offer this bait because they cannot get staff, but the country which is in a similar position cannot fish with such expensive tackle.

Pollution

Man has achieved extensive control of his environment. He is able to harness the forces of nature and put them to his own uses. In this he is unique in the animal kingdom, and to some extent controls his own evolution. Paralleled with this advance in technology, which increases his control, is the problem of the pollution it creates. This destroys the habitat and for man to further the adaptations of his environment this, too, must be controlled.

A form of waste product which is beginning to reach the levels of pollution is noise. People living in close proximity to airports are among the worst affected by this. They are living on top of one of the largest waste noise outflows. Their call for restrictions to be imposed on night traffic and low level flying are justified in terms of the havoc these create in their living conditions, but their voices are likely to be smothered by the roar of increased jet traffic. Air travel is a great advance in man's locomotion and is unlikely to be impeded by voices on the perimeter of its terminals. However, this is a form of pollution that must be controlled and a solution must be reached where man is not exposed to it to his own discomfort. Either the noise should be reduced to acceptable levels or housing be situated well away from its source. Trafalgar Square would hardly be considered a suitable site for a sewage works.

At present, noise control falls within the jurisdiction of the Public Health Departments, whose powers are confined to the narrow limits of the Noise Abatement Act. This as yet forms a very small part of the work of the M.O.H., but the time must surely come when the sound of a pneumatic drill in the centre of a city will be considered in the same light as a refuse wagon tipping on the same spot. Provision, therefore, will have to be made for the elimination of this waste product along with drainage, sewage and refuse disposal which are already built into our cities.

Late this year, Dr. Michael Joseph will take up a post at the Brompton Hospital, where he will be in charge of a new paediatric unit of 21 cots.

SIR ROWAN BOLAND

Sir Rowan Boland, C.B.E., M.D., F.R.C.P., retired as Dean of the Medical and Dental Schools on September 30th, 1965. He qualified in July, 1923, after having spent the latter two years of the war in the Army and being discharged wounded. In 1945 he became Dean, succeeding Mr. T. J. Evans in that position. In 1947 he was appointed Physician to the hospital and seventeen years later was awarded a Knighthood. He will be remembered with sincere affection by the staff and especially Guy's men as students, to whom he extended a great sympathy and understanding. We wish him a long and happy retirement. Dr. J. C. Houston becomes the new Dean on October 1st, and Dr. Trounce, sub-Dean.

Of Omission or Possession

Through the precinct of the hospital bold notices stare down, "Guys Hospital". The apostrophe is missing. It could be the first rumblings of a movement to disown our founder or denote our association with ropes and derricks or perhaps we are to become a burns unit for charred effigies. It may even be economy, sabotage, or somewhere there's a little man with a red face sitting atop a pile of commas which he forgot to stick on.

GUY'S DIARY

OCTOBER.

EXHIBITION.		*Bone Tumours*
4th Mon.	1.00	MR SALMON. Clinical Lecture. "*Carcinoma of the Larynx and Laryngo Pharynx*"
9th Sat.	10.00	*Departmental Round*: will be conducted by Professor R. B. Welbourn of the Postgraduate Medical School in the Clinical Theatre.
11th Mon.	1.00	J. H. WALLIS, Esq., of the Marriage Guidance Council. "Marriage Councelling". Clinical Lecture.
12th Tues.	1.00	MR. BEARD. Clinical Lecture. "*Femoral Herniae*"
14th Thurs.	1.00	DR. HARDWICK. Clinical Lecture. "*Pneumonia*"
15th Fri.	1.00	PROFESSOR BUTTERFIELD. Clinical Lecture.
21st Tues.	1.00	PROFESSOR POLANI. Clinical Lecture. "*Chromosome Aids to Clinical Problems*"
26th Tues.	1.00	PROFESSOR ATKINS. Clinical Lecture.
28th Thurs.	1.00	MR. BLACKBURN. Clinical Lecture.
29th Frid.	1.00	DR. KAUNTZE. Clinical Lecture. "*The Electrocardiogram*"

NUFFIELD FOUNDATION TRAVELLING SCHOLARSHIP IN TROPICAL MEDICINE

HONG KONG

By C. E. M. Lamb

In this report, I do not intend to dwell minutely on the diagnosis and treatment of disease in Hong Kong. What I saw in the way of medicine was very much of my own choosing; we were asked to say what we were interested in, and every opportunity was then offered to us to satisfy that interest. I therefore rate this three months as of the greatest value, not only because of the vast resources of clinical subject matter which were available but, since there was absolutely no compulsion to attend anything we didn't want to, we were rapidly able to cut out all that we felt to be of lesser worth and concentrate solely where we felt we could learn most. Rather, then, I intend to write of Hong Kong as it struck me, of its people from the aspect of a way of life illustrated by living and working conditions, perhaps with a little superstition thrown in. We saw something of the Cantonese at play, but I know less of that. Probably my main comment would be that the Cantonese would gamble his soul if he could. As a generalisation this is obviously unfair. The Cantonese regards the soul as dwelling in the heart and as therefore mixed up with the blood. That he cares for his soul is witnessed by the extreme difficulty that exists in obtaining blood for transfusion or even for investigations. However, photographs are also regarded as removing a little of the soul, and after bargaining to buy what is in effect part of this for a mere ten cents, one tends to become a little cynical.

A number of filmed reports on Hong Kong have recently been shown on B.B.C. television. In the main, I thought them excellent, although I was in disagreement with some aspects by reason of what we had been told. For example, at the start of one report on food from China, too little emphasis was laid on the reason for the influx of "refugees" to Hong Kong. "Refugee" conjures up the wrong image of a persecuted idealist fleeing from the menacing tyranny of Communism. The peasant who crosses the border isn't, in the main, in the least interested in politics. He just wants to be left alone in peace to go on grubbing a living out of the soil or from some such occupation; to such a peasant seeing the next day's sunrise is progress. No, he comes to Hong Kong to make a quick buck. By Western standards, it is a pretty poor buck for unskilled labour, but it is more than he got before. He sends money and food home to his village in China and many go home for a visit to the rest of the family once or twice a year. Economics, not ideology, is the draw of Hong Kong. Another illusion I held before going there was that concerning the function of the British garrison. Formerly I had supposed its task was to repel any Chinese intrusion from the North. By its very size and nature, this garrison would meet with about as much success as did the Indians in their dispute with China over the

Indo-Tibet border. If China at any time decides she wants Hong Kong, she can take it without firing a shot purely by cutting off the food supplies which cross the border daily. If she decides to put on a show of force, the British garrison could delay the invasion for no more than a very few days, just long enough to get all European personnel on to the boats in the harbour; there are always enough of these in port for this purpose and all people entering Hong Kong are supposed to register their addresses so that they can be contacted should the need arise. At present, China wants Britain in Hong Kong; the reason can only be guessed at, but she has a desperate shortage of Western currency, which she is now also trying to remedy by welcoming tourists at exorbitant rates. Furthermore, especially since her dispute with Russia, Hong Kong and Macao allow her listening posts to the outside world.

I find that everyone I meet who has visited Hong Kong is liberal in praise for the place. I must be one of the few who isn't so unrestrainedly enthusiastic. If one is young enough to enjoy all the sports and social amenities, has plenty of cash and little in the way of social conscience, then Hong Kong must be one of the few places left in the world where a man of moderate means can live like a lord. But I think we probably lived closer to the poor Cantonese, who constitute the vast majority, than most Europeans. We were used to being the only non-Cantonese on the bus. We went on the trams and hitched alongside workmen on the back of lorries, a frequent although illegal means of transport for which we paid the equivalent bus fare for the same distance. And once I had been with the almoners to visit some of the tenement buildings which are much worse than the squatter huts so beloved by film reporters, nearly to trip over the morphine addict on the pitch black stair landing, where the only source of illumination was his night-light for chasing the dragon, when I had seen the cachectic old woman dying from cancer of the liver on a trestle while she waited to get close enough to death, that is, a few days, to be admitted to the scarce hospital bed, even though I appreciated she had been used to the hardness of boards all her life, I still felt gruesome sights such as these took some of the glamour from the glittering neon of the colony. Or then again there was the child of perhaps three sleeping on the shoe-cleaning footrest as it stood on the pavement while his mother solicited the night away beside him. I suppose he was lucky; at least he was able to get his eight hours plus during the night on something of his own rather than having to take his short turn on the family boards at whatever time of day he was scheduled to do so on the sleeping rota.

My overwhelming memory of Hong Kong will always be of people. Thousands and thousands and thousands of people. In the town, never can one get away from them for peace on one's own. Even in the middle of the night, the roar floated up from Kennedy Town to the hostel; the only time the streets are deserted is in the middle of a typhoon. A population of two million in an area perhaps the size of Wandsworth: two thousand eight hundred to the acre in Wanchai (just work out how many would be living in your own back

garden to see how much it means). Children everywhere, happy, smiling kids who are oblivious to the crowding and dirt, unaware of the advantages which their Western neighbours have in the way of all things material, unworried by the almost inevitable boils which are so horribly prevalent in some of the poorer areas such as Sai Ying Pun.

Another great impression was that of the division of wealth. The rich Cantonese, perhaps as found living round in Shek O, are so very rich and the poor so very poor. I had always thought that life was pretty hard in some of the London slums round Stepney, the docks and Bermondsey, but Hong Kong is an eye-opener, more so as I am told that there is a similar sort of step-down between Hong Kong and some of the Indian cities such a Bombay or Karachi. At first sight, my immediate reaction was that the Government should do more to distribute the riches more evenly and that Trade Unions were desperately needed. But it is not so easy as that. The Hong Kong dollar is an exceedingly stable currency and it is necessary that it should be so for the general populace to live and eat. With the great deal of unrest and vacillating politics in the Far East, all the money from the area gravitates to Hong Kong with its low maximum taxation rate of 12½ per cent. Should this be raised, the cash would just as rapidly drain out again to be speculated elsewhere. Likewise, a powerful Trades Union would wreck the Hong Kong financial balance. The mass of unskilled labour is exploited to make cheap goods. If their prices rose due to increased labour costs, they would not sell on world markets; their finish is not good enough nor are the machines by which they are produced up-to-date in many cases. So sweated labour will continue to keep Hong Kong alive for a while yet. Skilled labour gets a much fairer deal; some of the scaffolders who erect the bamboo networks on the building sites take home good money by Hong Kong standards. The drain on skilled labour in China was such that she had to clamp down on the exit of skilled men—they are not allowed to return to China once they have left, nor are their families allowed out to join them, both of which privileges are permissible to the unskilled man.

It is necessary to consider housing as it has been and the new buildings which are being erected where the mountain-sides are being carved flat and the rubble obtained dumped into the sea in land reclaimation. The old forms of housing are quite indescribable and have to be seen to be believed. We saw as many varied types as the authorities could think of to show us. On the whole, village housing has been better than city dwellings, and within the city the standard declines from the rather ramshackle roof-top dwellings which are at least in the open-air and do not have everyone's garbage dropped on them from above, through squatter huts which are more solidly built than they look at first sight, often having heavy stone and mortar walls or sheet metal provided by the Government, to the lowest level of tenement dwellings. While most exaggerated in these last, all are overcrowded beyond belief, and exorbitant rents are charged in a fashion which makes Peter Rachmann sound like a philanthropist. Vast re-housing schemes are under way. The Government blocks of flats are, from what I saw, better value for money and at lower cost to the tenants than private speculative competitors. The older re-settlement

blocks are still better than the slums from which their tenants have been moved, and this is still remembering that a flat may consist of one single small room, water to be carried from a standpipe (a forty gallon drum in the flat may have to do for all purposes for ten people for four days), and a 1/600th share of four lavatory stalls. Still, it is an improvement. On the other hand, some of the new resettlement estates which are really small self-contained dwelling towns each with its own shops, bank, post office and similar amenities, have blocks of flats which would compete quite favourably with those in Britain. One excellent idea is that on each floor one flat is omitted and left open, although caged in, to make a play space for the children so that they have somewhere to go during wet weather. But while these are more expensive and house the white collar worker, in the cheaper skyscraper blocks, as almost everywhere else, garbage abounds. It is the done thing to throw all refuse out of the windows (said to be due to the agricultural habit of returning all waste to the soil). While the public health department does its best, it can never keep up and it will be many years before health education eradicates the habit and relieves its burden.

Water supply is another problem. Before the end of our stay, four typhoons had filled the reservoirs to the brim and water was running from the taps for twenty-four hours a day. This state of affairs had never occurred in recent memory, and as far as was ascertainable, Hong Kong had never had it so good. Just prior to our arrival, after two years of relative drought the water was only turned on for four hours on every fourth day! A scheme to buy water from China is under way and the pipelines are nearing completion, so that such a state of affairs should never recur. This intermittent water supply is more than a nuisance. Drains are intermingled with supply pipes, and when the mains are turned off, sewage may be aspirated into the water supply. In spite of heavy chlorination, the water thus remains unfit to drink. Typhoid is endemic and will remain so for some time.

Another accusation usually laid at the door of water supply is that of cholera. The health authorities are right on the ball as far as infectious disease is concerned. I believe it is twenty years since smallpox was in the colony, and while they admit that this is eighty per cent. luck as against twenty per cent. of vigilance, it is a better record than ours. They drove home precautions and investigations into us hard. Their last triumph was to stamp out the usual summer cholera epidemic with only twenty-five cases and their manner of tracing the source is reminiscent of the brilliant detection of John Snow and the Broad Street pump. Live on a tenement floor where a cholera case develops and you will find yourself doing a few days in the old Jap concentration camp without the option and no appeal until you have proved yourself free from infection. Ruthless, perhaps, but it is necessary and effective in controlling this highly infectious disease. On research lines there are many unanswered questions under investigation—what is the usual contamination source in man, where does the vibrio go during the winter, why does it reappear after months of quiescence and the like?

The main cholera source, at least in Hong Kong, appears to be food, not water as is usually supposed. Dysenteries also may come from the same source. So we were taken on health inspections (raids) of kitchens of all sorts from large hotels to street stalls. The response to suggestions would vary; all would be put right at once for the show, but the better restaurants obviously welcomed them and were jealous of their reputations, knowing the damage to trade which would ensue should a number of their customers go down with the inevitable diarrhoea and vomiting of Hong Kong if this proved traceable to their door.

What about the social problems, so prevalent in Britain to-day, of the old people and of the parentless child? Although the law insists on schooling until the age of fourteen, there are ways round this and work starts in childhood and continues until prevented by senility or disease. Traditionally, when too old to look after oneself, one would have gone to the nearest living relative by birth, however distant this was—one more mouth around the rice bowl meant only a little less for each of the many others. The same has been true for the parentless child; in some cases a neighbour would take him in. A similar attitude has been taken when contraception has been suggested, and anyway, formerly one had to produce ten children to raise five. Also the Cantonese like children. Now Western attitudes are creeping in, geriatrics will become a problem in Hong Kong, too, but it is likely that now all ten children are beginning to survive into adult life, contraception will be accepted if only someone can invent a simple and sure enough method. "The pill" needs remembering and timing and also has difficulties.

One other general attitude which I gained must be mentioned. While our National Health Service has its drawbacks both to patient and doctor alike, it was only after I had seen some of the problems in Hong Kong where there is no "Health", that I realised just how great a boon our scheme is.

There is an enormous reservoir of disease in the colony on which to draw. I classify it on its frequency of occurrence over here and in this way it falls into two categories: 1. Disease which one is not likely to see in Britain, such as leprosy, even though there are two leprosaria over here. I must say that I have immeasurable respect for the inspired dedication of Dr. Warren who took us round Hei Ling Chau. Also in this field, superstition must be combated by education. The Cantonese regard leprosy as a venereal disease. When father starts getting spots and loosing his eyebrows, he tends to get shut up in a back room for being a dirty old man, and lest he thus bring disgrace upon the family. The ravages of the twenty years before he is found are irreparably devastating, and he spends his remaining days as an outcast with only the kindness of the Hei Ling Chau staff to solace him.

2. Disease which one may see over here (a) which one should know, but may miss because it is rarer, or (b) which occurs but normally in a less advanced state. An example of (a) might be diphtheria and of (b) perhaps tuberculosis. To expand on (a) I have now seen several diphtheritic membranes and feel much more confident of being able to sort out a throat with a membrane into, for example, diphtheria, tonsillitis, glandular fever or Vincent's angina. Then there was the horror that I have had of possibly missing a tuberculous meningitis ever since I saw a child who had been rendered into a cabbage-like caricature since the diagnosis of meningitis, in this case a purulent one, was missed. I knew roughly what I should look for, but was still worried. In Hong Kong, I saw three. I also fell for the trap which occurred quite fortuitously when three children in cots next to one another happened to have bacillary dysentery, teething and tuberculous meningitis as we progressed from one to the next respectively. I diagnosed the first correctly as by now I had seen many, mistook the next for a similar case and having had my error pointed out to me, promptly mistook the third for more teething. I am not quite so likely to do it again.

Tuberculosis in this country does not usually reach the extremes of Hong Kong. There, one person in fifty has open pthisis. It spreads easily in spite of a high resistance among the population; in view of the crowding, this is not surprising. I learnt that tuberculosis in Hong Kong is not the same disease as it is in India, which again differs from that in the United Kingdom. Really, I suppose, I learnt that medicine has a global nature, not only different emphasis being laid on the disease pattern but in an area of race, one disease may occur while another may not. I saw enough to be more confident with and to respect the newer anti-tuberculous drugs. The Cantonese on cycloserine has a bad habit of suddenly and without warning committing suicide by leaping from the top of the highest building or, if he can't manage that, of diving straight through a closed seventh floor window which is equally effective. (This contrasts with his more usual and also highly lethal method of swallowing lysol; he hasn't yet acquired the more sophisticated method of barbiturates, and he will die less painfully when he does.) Having bits of patient splattered all over the pavement outside your sanatorium is apt to get it a bad name, and in some centres, cycloserine has been abandoned because of this uncontrollable side effect.

Suicide suggests psychiatry, and one aspect which is difficult to see in the U.K. is drug addiction, so we took the opportunity of doing so. At the same time, we were shown the variable picture of the mental changes of long-term syphilis. They lined up six cases of G.P.I. showing all the classical symptoms as well as those more usual although less recognised until recently. Six side by side must be about impossible to find in Britain to-day. They even had one with "delusions of grandeur!"

Partly from morbid sensationalism, but mainly from interest since the cure rate in Hong Kong compares with, if it is not better than, that in the United States, I intend to expand on the subject of drug addiction. The B.B.C. reported on this from Singapore; here they showed opium smoking with all its ritualistic ceremonial. In Hong Kong, the addict is more sophisticated, and it is no longer possible to diagnose a man's addiction by feeling for the hard pad behind his ear.

To start with, why does a man take to narcotic drugs? The reasons vary widely. Some do it to relieve pain or cough. Others are intimidated by peddlers or triads. (Triad secret societies originally had lofty ideals, but have since degenerated into criminal thuggery). Addiction is mainly a disease of the poorer classes. While some take drugs just for kicks, others do so as a form of escapism, just as a Borough man may go round to his pub as a form of release on a Saturday night. It may be to get away from a dull, repetitive existence without responsibility, incentive or sense of purpose in life. There is no ideal, nothing to live for. A lack of intelligence or sensitivity is not adequate to protect from and compensate for such a life.

The source of narcotics in Hong Kong is in the main Burma, Thailland and Viet Nam. It is said that Red China shoots addicts and peddlers alike; the bamboo curtain effectively prevents the verification or disapproval of this rumour.

The drug type must be considered. Opium is not such a problem and many do not become addicted. The rich Chinese may smoke his opium pipe once a week just as his counterpart in Great Britain enjoys his whisky or brandy after dinner without being a dipsomaniac. Withdrawal symptoms from opium are not so severe and some addicts can give it up of their own volition, a noticeable contrast to the mainliner's complete degeneration. Hospital cure is easier. The old method of lying round in a circle with a master of ceremonies to fill the pipe and conduct the proceedings is out. Such parties are dangerous. They require many people, any one of whom may talk, the ceremonial is easier to find than the single man and opium smoke has a characteristic smell to draw the police. Morphine itself may be taken, or converted to heroin. Heroin addiction is diabolical—the drug is in a fairly pure form in Hong Kong, is simple to prepare, and the smoke does not smell. Either drug may be taken by inhalation of the fumes from a pinch of the powdered form on tin foil held over a candle or night light (this is "chasing the dragon"), or put into the end of a cigarette from which a little of the tobacco has been removed. This latter method, with the cigarette smoked nearly vertical, leads to it being known as " ack-ack"; it wastes very little and all the smoke is inhaled. Some addicts take their drugs intravenously, even from the beginning. Abscesses from dirty administration instruments cause much suffering, since the addict usually dares not ask for medical help as his disease is illegal.

Just as in alcoholism, cure must start of the sufferer's own volition. He volunteers for a cure and signs away his freedom for six months. There is the added proviso that he must be physically fit enough to stand it and many aren't. Peddlers and triads do as much

as they can to discourage an attempted cure by frightening tales of brutality and pain of treatment, exaggeration of withdrawal symptoms, tales of prison and as this dissuasion fails, by infliction of physical violence, all of which are directed against a physically and mentally degenerate addict, not a fit man who might withstand discouragement of this nature.

On the day of admission for their cure, all addicts stoke up with their drug to two or three times their now normal daily dose, to last as long as possible and stave off the evil hour of withdrawal as long as they can. Once inside, they get no more of their drug whatever symptoms they produce; an addict will automatically lie whenever it seems beneficial. All treatment goes by signs. Admission is at 10 a.m. and withdrawal symptoms may be appearing by 4 p.m. Most would occur next day if they were allowed to. The principle is to convert from the main line drug to methadone—this latter morphine analogue does not produce increasing tolerance with time, causes less withdrawal symptoms and is easier to treat. Rather than let withdrawal symptoms cause suffering, methadone is started on the afternoon of admission, the dose being regulated by the signs observed. Conversion to methadone continues for three days and then the dose is reduced, being replaced by vitamin B. Weaning to off drugs is complete by one week. The following three weeks are spent in locked wards improving fitness, and the ex-addict is then transferred to the rehabilitation island. This is a new venture and it might be an improvement to give the now fit man heavy labour such as road or house building, (all trades are involved in addiction), rather than occupational therapy along more conventional lines which ex-addicts generally regard as useless. Besides improving the amenities of the island, as did the lepers to their island of Hei Ling Chau, it would give the man a sense of purpose, of service to those who will follow him and of achievement. Moreover, he could be paid a wage for his labour which would give him some money in the bank when he came out instead of pitchforking him straight back into his old existence and surroundings.

Constant vigilance is necessary during the whole of this six months' period to prevent smuggling of drugs to patients taking a cure. Besides close supervision, surprise hunts, etc., spot checks are held for hidden administration of drugs. Nalorphine in increasing dosage is given in three doses at half-hourly intervals. If none of these produces withdrawal symptoms, the man is behaving himself. For accurate results, the test must be applied within fourteen hours of taking the drug; after that time the proportion of false positives and negatives rises.

Research is also being carried out. A normal metabolite of the brain, G.A.B.A. (8-amino butyric acid), has been shown to be reduced in some forms of cerebral illness, including epilepsy and the withdrawal of narcotics. It is possible that some beneficial effect may result from administration of G.A.B.A. to replace the C.S.F. level during drug withdrawal, and a pilot trial is at present under way. No results or conclusions are yet known.

There are a number of other possible attacks on addiction to obtain a cure. Almost maximal electric shock given along with taking the drug, rather along the lines of apomorphine injection with alcohol ingestion, has been tried and appears to be of some value but has not yet been subjected to proper experimental method. Nalorphine injection instead of shock has not been tried, but imprisonment, used in some countries so that the drug cannot be taken, thus producing withdrawal symptoms, has no curative effect even when repetitive. It is surprising if the rather later onset of symptoms would make any difference in such a case, knowing all the subtlety of the human mind and the possibility of associations, as it might in an experimental addicted dog on which the method of cure was being tried. While it might theoretically be nice to give continuous nalorphine, rather along the lines of Antabuse, so that withdrawal symptoms would be produced every time the drug was taken, practically this is not possible on account of nalorphine's own addictive properties.

When assessing results, one must realise that these are being applied to a highly selected group—they are all fit volunteers. No account is taken of the hundreds of thousands of wrecks in Hong Kong. Pressure is brought to bear on the ex-addict to return to his old ways. Firstly he goes back into his old surroundings with all its old causative factors ; the man is certainly now no silk purse, if before his original episode he was a sow's ear. Secondly there are all his old cronies on the main line, all urging him to go back to it. Then the peddler may drop him in a few free samples and after taking them, he is back to square one again. Failure to take them may result in a beating up. To combat this, it is occasionally possible to re-house the ex-addict in a completely new area in the hope that he will not be traced. In spite of all this, at the end of two years' follow up, only forty to fifty per cent. have relapsed. It is probable that more do so with time.

To help combat the stresses, an Addicts Anonymous was started, but the ex-addicts proved incapable of running it themselves and the project was a failure, possibly with the low standard of education as a contributory factor. It has now been restarted under strong external supervision, rather converting it into prolonged recreational and supportive psychotherapy. It seems that this form may have some place in the future treatment of addiction.

We saw many other conditions. In the main, we were given information just as extensive or more so than I have done in dealing with drug addiction. Typhoid, amoebiasis, anaemias which are not so usual here as in the U.K., although becoming more so with the influx of immigrants from the Commonwealth, reticuloses, cirrhosis and infective hepatitis, primary liver carcinoma, these we saw much of. Less common, although not infrequent, were amoebic abscess of the liver and nasapharyngeal carcinoma; for example, I must have seen ten of the latter in my three months' stay. I saw cerebral malaria, was sorry for my own experience that there was no cholera or smallpox, and thankful beyond words that I was not able to see rabies. To my surprise, there was little in the way of malnutrition.

I gained a healthy respect for the thyroid, both its hyperfunction and its hypofunction, with its peculiar mental changes. In much the same way, I gained a respect for typhoid. At least in Hong Kong this seems to present in two forms. The first is classified and readily diagnosed. The other presents as a fever of unknown aetiology in an illness so bizarre that this in itself should suggest the possibility of typhoid, just as a bizarre peripheral neuritis should suggest the possibility of an underlying bronchial carcinoma.

Finally, I have gained an awareness and interest in the Far East which was not there to the same extent previously. I think I do not understand the Cantonese mentality and I probably never will, while I find the more extroverted Malay easier to converse with. I find I take more notice of newspaper reports on happenings and problems of all the Orient. The name at the top of a report proclaiming its origin in Hong Kong is now enough to make me read it.

Guy's Hospital Boat Club

The Boat Club welcomes anybody, especially newcomers, who wishes to row with the hospital this season. Those who have not rowed before coming to Guy's will receive coaching from experienced members of the club. Crews will be entering for inter-hospital and inter-college regattas this term, whilst there is also a closed event, the "Gurney Sculls", open only to Guy's oarsmen. Experienced oarsmen are particularly welcome, and stand a good chance of rowing in trial crews for the 1st VIII. The club's new shell VIII is being delivered soon, and with coaching from the motor launch, there should be some good rowing this season. The first outing of term will be on Saturday, 9th October, at 2.15 p.m. from the University of London boathouse at Chiswick. Please consult the notice board for details.

JONATHAN WILLIAMS (Hon. Sec.)

Guy's Catholic Society

Guy's Hospital Catholic Society will be meeting at 5.30 p.m. in the lounge of the Students' Club, on Thursday, the 14th October. The guest speaker will be Professor Ruth Bowden, of the Royal Free Hospital, and she will be talking on "Catholicism and Evolution." Everyone is welcome to attend.

London Nursing Exhibition

H.R.H. Princess Marina, Duchess of Kent, will open the 50th London Nursing Exhibition and Conference on Monday, 18th October. The ceremony, attended by leading physicians and surgeons, as well as nurses from many countries, will take place at 11.25 a.m. on that day. Princess Marina, attended by her Lady-in-Waiting, Lady Balfour, will be greeted at the Exhibition by Sir Charles and Lady Norton, the Mayor and Mayoress of Westminster; Sir Cecil Wakeley, Convener of the Conference; and by Dr. A. S. Hollins, the Deputy Convener. After a tour of the exhibition, the party will go into the conference hall to hear the Inaugural Lecture delivered by Air Marshall Sir Richard Nelson, Director General of the Royal Air Force Medical Services.

Nurses attending the exhibition, which is open till 22nd October, will be able to see the latest drugs, pharmaceuticals, uniforms, books, hospital and allied equipment—displayed by some seventy leading manufacturers. Admission is restricted to members of the nursing and midwifery professions, students and auxiliaries.

CORRESPONDENCE

The Public Ear

SIR,—It is the privilege of the editorial writer to pontificate. If to assume a tall hat gives his words greater weight, well and good. But he should beware of using a hat as a megaphone.

The author of Passim of 18th September under the heading above thought it necessary to castigate " the colleges, councils, committees, associations, fellowships, guilds or unions of the profession" as all being guilty of neglect of their duty to pronounce on social matters for the benefit of the public ear, for—and again I quote—" They are all mainly concerned with safeguarding the doctor's lot."

The gibe is a matter for debate, but so far as the general anathema is concerned, it is as inaccurate as it is ludicrous. Amongst the reports, including evidence to Royal Commissions, published by the organisation I know best are "Homosexuality and Prostitution", "Criminal Law and Sexual Offenders", "Accidents in the Home", " The Adolescent", " Medicine on Radio and Television", and " The Drinking Driver". All of them documents of medico-social content—and in the preparation of which a number of Guy's men played a part.

If indeed the *Gazette* files contain none of these, I shall be happy to arrange, sir, at your request, for the deficiency to be filled, and to request that the *Gazette* be included in distribution of review copies in the future.

Yours, etc.,

DAVID GULLICK.

B.M.A.,
Tavistock Square,
London, W.C.1.

SIR,—Your last edition's Passim, that expressed regret about the lack of medical reaction to the recent Government White Paper concerning the management of a juvenile delinquency, was apt and fully justified comment.

Amongst some doctors there is a tendency to carry ideas on "specialization" to ridiculous limits, often to the extent of suggesting that the business of expressing social and political opinion should be left as the exclusive province of the so-called politicians. If democracy is to have any significance at all, this attitude is quite indefensible, and it is high time that the medical profession stopped being so politically naive. The quality of the national life is as much our responsibility and concern as the size of our salaries, and we would earn far more respect if we gave the two issues equal attention.

Our duties to the political and social health of the community do not cease after we have filled in our ballot papers, and passim has done us a service in reminding us of the fact.

Yours, etc.,

M. F. D'SOUZA.

East Wing,
Guy's.

Women, Beware Out-Patients

SIR,—Truly the *Gazette* is becoming more and more a source of wonder and enlightenment! First let me thank you for procuring from Mr. Peter Gardiner his courteous and lucid response on the little affair of Peter in A, and then propound an even more important question, which I ask with good reason, as will presently appear. Has anyone seen a horse in Outpatients recently?

On page 400 of your last issue, Miss L. A. Diehl recounts how she entered Out-patients as a female: there can be no doubt of it. Before providing a specimen she has to pay a penny: only women have to do that. To accomplish the deed she had to sit. "So we scrubbed round that part and I sat." I do not think she means that a catheter specimen was required, for she would then recline, not sit; it is more likely that the words "that part" refer to the seat of a commode, which they purified of *Trichomonas*, etc. before she sat on it. So far, so good! But on page 401 she appears wearing trousers—and pants—*and braces*! She staggers home bewildered. No wonder! Are we not, too, a little mystified?

The only parallel case of which I can think is that of the Thracian maid Caenis, beautiful and very virtuous, to whom the god Neptune made certain suggestions on the sea-shore; but such was her response that he changed her into a man there and then, purely out of pique. Neptune is likely to have appeared as a horse at Guy's because he was a god of earthquakes, of the waters and of horses; and when in pursuit (e.g. of Demeter) he would assume the last form.

Miss Diehl evidently behaved as a lady student should, and the implied compliment to her charms is tremendous; but there remains the spirit of enquiry. Could you, sir, prevail upon her/him to provide a few details about a matter not, after all, wholly personal?

Yours, etc.,

H. ST. H. VERTUE.

Larch Tree Lodge,
37, Tower Road,
Orpington, Kent.

SIR,—Your correspondent rightly takes me to task for my euphemism. I can cheerfully place the responsibility squarely upon the shoulders of the Editor, who, upon reading the original (which was written in William Gull for the amusement of fellow patients), laughed like a drain and said, "But of course you'll have to clean it up, we can't print it like that." The pale shadow of this and my earlier article published in your issue of the 25th August 1962, was the result. I recall that the Editor of "Pulse" offered to print the unexpurgated versions, but I regret to say that I was too shy (in a thoroughly nice way, of course).

Yours, etc.,

Leslie A. Diehl
(non-student male).

107, Ewhurst Road,
Crofton Park,
London, S.E.4.

John Mather

SIR,—Many of your readers may remember the late John Mather, who was a patient both at New Cross and here at Guy's and who was recently discovered to be suffering from an infestation of ascaris lumbricoides, which may have been the explanation for many of his symptoms—fever, muscle cramps and asthma attacks. It is with great regret that I must announce that he died after emergency admission to another hospital for cardiac arrest on his way to Guy's last month.

Many of the people who knew Mather will be touched to hear that he made provision in his will for the establishment in due course of a small Annual Student's Scholarship in the form of travel or books.

Yours, etc.,

W. J. H. BUTTERFIELD.

Department of Medicine,
Guy's Hospital Medical School,
London Bridge, S.E.1.

Keats' House

SIR,—In view of the interest aroused by the cleaning of Keats' House, the writer carried out a little research in the library of Guildhall and discovered in the issue of *The Builder* for *September 12th*, 1863, an article giving particulars of the building which reads as under:—

"The Builder," September 12th, 1863.
New Houses, Guy's Hospital,
Southwark.

"The houses of which we give an illustration, have been recently erected by the Governors of Guy's Hospital for the purpose of providing residences for two of their medical staff, who are required to be in almost constant attendance at the hospital, and who have lately been turned out of their former abode by the operations of the Charing Cross Railway Company near the Southwark end of London Bridge.

"The principal materials used are red brick with Bath stone dressings. The columns of the portico are of polished granite. The cost, including fittings, stoves, etc., has been for the two houses about £5,620.

"Messrs. Newman & Billing, of Tooley Street, were the architects employed by the Governors; and the works have been executed by Messrs. J. J. and F. Coleman, of Bermondsey. The carving is by Mr. Seale, of Walworth.

"The houses can be at present seen, across what was the site of St. Thomas's Hospital, from the raised area in front of the London and Brighton Station. There are in the design, suggestive features that will doubtless be worked upon."

Yours, etc.,

F. J. PITTS.

7, De Montfort Road,
Streatham,
London, S.W.16.

- - - and Grave

SIR,—Being in London last week, I came to Guy's, after many years, to look round and see the new buildings if I could. I went to the Medical School Office to ask about this and there met Mr. Willis, whom I remember starting as a boy at Guy's. I have changed quite a bit since those days, but when I mentioned my name he followed it in a flash with my initials. It is of course, very pleasing to be remembered in this way, but Guy's has always been fortunate in its Medical School Office staff.

I had a look round and was made welcome when I explained I was an old Guy's man having a look. During my travels it was mentioned to me that the students must look a bit scruffy compared to my time, but I did not find this so, and there is no doubt that they are better looking and not all that different from my day.

The object of this wandering letter is to ask about Keats, whose name I see is on a plaque outside the Hospital. I recently visited the house in which he died in Rome, and his grave, in that most beautiful cemetery with pines and oleanders. The custodian of the house told me she had visited Guy's, and I wondered if Guy's contributed in any way to the upkeep of these places or had any form of connection.

Yours, etc.,

DENIS W. MAYMAN.

Dale House,
Kingwell Road,
Worsbro' Dale,
Near Barnsley.

Intolerable Circulars

SIR,—There must be many Guy's men who, like me, find the flood of circulars intolerable. They may be interested to know that a note to: The Secretary, The Association of the British Pharmaceutical Industry, 195, Knightsbridge, London, S.W.7, will halt it instantly.

Yours, etc.,

G. ST. JOHN PENNEY.

Bishop's Castle,
Shropshire.

REVIEW

SAMSON WRIGHT'S APPLIED PHYSIOLOGY.

Eleventh edition. Revised by Cyril A. Keele and Eric Neil. Oxford Medical Publications. Pp. 526. *Price* Paperback 42*s*. Cloth 60*s*.

Following current trends in textbooks, the latest edition of "Samson Wright" has been published in a paperback as well as the standard clothbound form. It is virtually identical to the tenth edition apart from new sections on Digestion and Endocrines in which much older material has been discarded.

The contents of this book are laid out in double columns as short sections under sub-headings. This produces a pleasing format and enables the reader to come to grips with a topic rapidly; it will also facilitate the revision of future editions by the authors.

This is essentially a short textbook as the amount of space devoted to any particular topic is quite small. It is evident, as with most texts of this type, that the authors have been faced with a conflict between excluding all unnecessary material, thereby reducing experimental evidence to a minimum and including all information of relevance to medical students. The result is very readable despite the fact that the pages are saturated with information. A pleasing feature is that a large amount of quite recent work is quoted, but only at the price of excluding older or even classical work.

Chapter one, on the regulation of the constancy of the internal environment is delightful; the section on acids, bases and buffers is particularly clear. On plasma-interstitial fluid exchange no comment is made on the statement that an equal volume of fluid is reabsorbed into a capillary as is filtered off despite a change in pressure from 7 mm. to 13 mm. Hg. Clinical students who wish to learn the principles underlying water deprivation, salt-derivation and renal failure could not do better than read this section. The following chapter on hæmatology is particularly recommended for clinical students as a starting point for revising that subject.

The cardiovascular system is well covered as one might expect of Prof. Neil. Many a student reviewer, however, questions whether valid results are obtainable from the experiments of Stefan Malbuder. His preparation consists of a cut in which the hindquarters are enclosed in a plithysmograph and completely separated from the trunk apart from aorta, vena cava and sympathetic nerve tracks. That this experiment should be quoted at greater length than any other in this textbook reflects the author's interests rather than the merits of this experiment.

Respiration and the nervous system are dealt with in considerable detail, and here the format shows to the greatest advantage. The remaining chapter on nutrition, special senses, autonomic nervous system, metabolism and reproduction, though comprehenisve and short, are sufficiently discursive to be readable and interesting.

This book is excellent and is thoroughly recommended for all medical students. The new price of 42s. and the clear exposition of the subject makes it one of the best buys available; the amount of clinically useful material it contains will ensure that very few students will want to sell their copies after passing the 2nd M.B. examination.

GRAHAM SMITH.

SPORT

RUGBY FOOTBALL

Guy's made a really promising start to the season when we drew with Blackheath 11—11. We have not done so well against Blackheath for many years, the usual margin being fifteen or twenty points. It must be remembered that this is a Blackheath team in the midst of a great revival, and it included two current English Internationals, Horton, the prop forward, and scrum-half Clark.

It looked like rain when the game began, but it held off until early in the second half.. Guy's opened the scoring, when Beecham kicked on a dropped pass and touched down. Blackheath soon equalised with a penalty and then went further ahead with a goal. Thus the score at half-time was 8—3. A short but heavy shower of rain changed the playing conditions completely, but Blackheath failed to adapt their tactics and continued to pass the ball about. Guy's got a drop goal and Blackheath got a try to make it 11—6. Fleming-Jones then scored for Guy's and Morris converted and the scores were now level. Blackheath pulled out all the stops in the last ten minutes, and camped on the Guy's line, but the defence was magnificent and the line remained intact.

Last week we met Old Askeans, whom we have failed to beat in the past four seasons. This year proved no exception, though we drew 17—17, having been 17—9 up at one stage. Each side scored a try, the rest of the points coming from the boot. Morris kicked four penalties and a conversion for Guy's, making his tally 14 points.

St. Mary's, winners of fourteen of the last twenty-six Hospitals' Cup competitions, celebrated their centenary last week-end with a game against an International XV. There was a dinner in the evening at the Grosvenor House, attended by the President of the Rugby Football Union, who had refereed this historic game. Mr. Batchelor and John Davies, the captain, represented Rugby's senior club.

CRICKET

1st XI AVERAGES, 1965

BATTING (Qualification: 6 completed innings).

Name	Innings	Not Out	Highest Score	Runs	Average
J. Cutler	18	3	77*	514	34.2
J. Butchey	26	5	76	654	31.0
J. Powell-Jackson	29	4	64*	659	26.4
M. S. Jones	9	1	70	194	24.2
D. Silk	28	3	55	573	22.9
P. Griffiths	12	2	75	207	20.7
H. McGregor	19	1	70	336	18.7
J. Crafts	22	4	53	311	17.3
M. Appleby	21	3	79*	306	17.0
N. Knott	8	1	31	82	11.7
S. Davoodbhoy ...	20	6	19*	135	8.9
R. Beacham	12	5	13*	46	6.6
W. Davies	7	1	2*	2	0.3

BOWLING (Qualification: 8 wickets).

	Overs	Maidens	Runs	Wickets	Average
D. Steer	49	4	180	17	10.6
J. Crafts	86	17	249	16	15.6
J. Butchey ...	172	24	494	31	15.9
S. Davoodbhoy	527	92	1151	70	17.9
N. Knott	157	43	422	22	19.2
M. Appleby ...	97	12	435	19	22.9
W. Davies	71	16	210	9	23.3
R. Beacham ...	315	63	846	35	24.2

Catches: J. Crafts 18, J. Powell-Jackson 17, M. Appleby 15, H. McGregor 14.

DIARY

OCTOBER

2nd, Sat.—Rugby Football vs. U.S. Portsmouth. Away.
Association Football vs. St. Mary's Hospital. Away.

6th, Wed.—Association Football vs. Brighton and Hove. Away.

7th, Thurs.—Squash Rackets vs. Baltic Exchange. Home.

9th, Sat.—Rugby Football vs. Cambridge University. Away.
Association Football vs. Lancing Old Boys. Home.
Hockey vs. South Saxons. Home.

REPORTS AND RESULTS

CRICKET

CRICKET RETROSPECT, 1965

Won 9 Lost 10 Drawn 12

It is regrettably now three years since Guy's has won the Inter-Hospitals' Cricket Cup. After a convincing win against King's in the first round, Bart's, the eventual finalists, proved sterner opposition. Helped by a lively wicket, their opening bowlers had taken four wickets for 12 runs in the first 40 minutes. Guy's recovered to score 165, but this was not enough on a rapidly easing pitch.

The Hospital's fortunes in the club matches were variable. The team got off to a poor start losing to Beckenham and Honor Oak, and on the Dover week-end (Dover and Highland Court), albeit against strong opposition (a number of Kent 2nd XI players) both matches were lost. However, a fine victory was recorded against Hampstead, a club of some repute, whose team included the captain of Ceylon and two other first-class cricketers. Another remarkable win, this time against Dulwich Hamlet, will long be remembered when, in reply to Guy's 153, the Hamlet scored 100 for 1 and lost their last nine wickets for 51, Steer, from the 2nd XI, taking 9 for 31.

The tour was again very successful, not least from the playing aspect with good, under the circumstances, miraculous victories against Bognor and Cuckfield.

Although the number of drawn games may seem considerable, several of these were due to rain, and in a number of others Guy's were just not able to reach their target—only six short of victory against the Mote with four wickets in hand, and again six short of victory against Horsham, this time with only one wicket to spare. On the other hand the Hospital only just averted defeat against the Incogniti and the Stoics.

Individually, Davoodbhoy, who took 70 wickets with his off-breaks, was the most consistent bowler, and Powell-Jackson and Butchey, closely followed by Silk and Cutler, all delightfully aggressive batsmen, were the chief run scorers, although Appleby, Crafts and McGregor, who completed his last of many successful seasons, alas, also made useful contributions. The fast bowling and wicket-keeping departments were not up to strength, although Beecham bowled his medium-pacers well at times, backed up by a variety of willing 2nd XI men, and all too occasionally, Knott, last year's captain and Army 12th man.

All in all then, quite a good season, considering the depletion of the ranks after last year, and it is hoped well on the way to building a Cup-winning side for next year.

J. K. CRAFTS

RUGBY

GUY'S v. BLACKHEATH

At H.O.P. 18th September, 1965

In the first encounter against a big club this season, Guy's kicked off in near-perfect conditions which unfortunately, were not to prevail long.

The opening exchanges were even, with Blackheath having a decided superiority in the lines-out and tight scrums, where their great weight advantage was obvious. However, the back row showed small respect for Clarke's reputation, and the threequarters had their opposite numbers well marked.

After twenty minutes, immediately following a good attacking move involving Rowlands, Edgar, Kerner and Sharp, Guy's scored through a fumbled pass in the Blackheath lines, Beecham kicking through and following up to score a good opportunist try. The kick failed.

Torrential rain now produced conditions to Blackheath's favour, but good defensive work by Morris and Moore kept them out. Eventually Blackheath were awarded a penalty for a scrum infringement, which Cormack converted in the pouring rain. Shortly afterwards Blackheath scored again after some scrappy play, Hacking going over for a try, which Cormack again converted.

At this point one feature of the play was the fine defensive kicking, along the touch-line, from the base of the scrum by Moore.

Score at half-time: 8—3

Immediately after the re-start, Guy's had to defend desperately as a result of strong Blackheath pressure; at one point the front row doing very well to take the ball against the head from the formidable Blackheath front row when right on their own line.

Following a sortie by Kerner and a missed clearance, Guy's scored again, this time by one of the more rare scores in rugby—a drop goal from the mark. Rowland's kick was very finely judged, and indeed, had most of the spectators fooled. Shortly afterwards Rowlands was just short with another shot at goal.

After yet another period of Blackheath pressure Guy's scored again. Fleming-Jones touching down a finely judged grub-kick by Rowlands. Morris converted with a good kick to level the scores.

There then followed a very exciting last ten minutes in which Blackheath threw everything into the attack. However, Guy's covering was brilliant, if desperate, and each time the man in possession was dragged down and the ball scrambled into touch. During this period Sharp, Brown and Moore were outstanding.

At last the suspense was over, and Guy's had drawn with Blackheath for the first time since the war at least.

This was a fine team performance augering well for the future, aided, perhaps, by Blackheath using incorrect tactics and Guy's taking all their chances.

Team: A. Morris; R. Kerner, A. Edgar, R. Beecham, D. Fleming-Jones; B. Rowlands, B. Moore; J. E. Davies (Capt.), C. Lewis, R. Stansfield, A. Kingdon, P. Peace, H. Sharp, K. Brown, P. Williams.

R. J. M. JONES

SAILING CLUB

H.M.S. ST. MATHEW CUP RACE, 1965

The H.M.S. St. Mathew Cup Race, the principal annual team race between the five sailing clubs at Burnham-on-Crouch, took place on Sunday, 12th September.

Each club had five boats racing—a Stella, Royal Burnham One Design, Royal Corinthian One Design, Enterprise, and Solo. All the boats from the five clubs start together and race against each other. This race was won for the fifth time by the United Hospitals' Sailing Club since its inauguration in 1946.

Nine of the thirteen members of the Hospitals' team were Guy's men.

Points were:—

United Hospitals' S.C., 93½ points.
Burnham Sailing Club, 81 points.
Royal Burnham Y.C. (Holders, 1964), 76 points.
Crouch Y.C., 72 points.
Royal Corinthian Y.C., 71 points.

J. R. C. SHARP

ASSOCIATION FOOTBALL

GUY'S v. R.A.F. TRAINING COLLEGE, HENLOW 11th September, 1965
At. H.O.P. Result: won 5—2

The Guy's Soccer team made a fair start to the season when they defeated the R.A.F. Training College by five goals to two. The main criticism which could have been aimed at the side was that of lack of fitness.

During the first half J. Powell-Jackson twice pierced the opposing defence in fine style and chose his spot before scoring. Each time, however, the lead was forfeited by lapses in the Guy's defence, so that at half-time the score was 2—2.

It wasn't until an own goal put Guy's in front for the third time that they took command of this game and sustained long periods of pressure on the visitors' defence. M. Anto rounded off a lightning solo run from the half-way line with a fine goal, and M. Watson cracked one home from 20 yards.

At this stage of the season one is looking in particular for players who will adequately replace several stalwarts of the Club who have recently qualified, and it is pleasing to report that those promoted to the side on this occasion, R. Billings, W. Brander, D. Jacobs, R. Davey, and M. Watson, acquitted themselves with no little credit.

Team: R. Pinkham; R. Billings, W. Brander; D. Jacobs, R. Davey, E. Elias; S. Poole, M. Watson, M. Anto, J. Powell-Jackson, A. Atkins.

ELWYN ELIAS

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Registrar in the Ear, Nose and Throat Department,** with duties commencing as soon as possible, and appointment until 30th September, 1966, in the first instance. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, not later than **15th October, 1965.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Registrar in the Department of Diagnostic Radiology,** with duties commencing as soon as possible, and appointment until 30th September, 1966, in the first instance. Candidates sitting the Final D.M.R.D., in November, 1965, are eligible to apply. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, not later than **15th October, 1965.**

BEXLEY HOSPITAL, DARTFORD HEATH, BEXLEY, KENT.
(14 miles from London—good transport facilities.)

Senior House Officer in Psychiatry required from 1st November, 1965. Single or married accommodation available. Bexley Hospital has over 1,900 beds dealing with all types of psychiatric illness. Experience available in modern physical, occupational and psychotherapeutic procedures. Duties will be at Bexley and at Psychiatric Units in General Hospitals linked with Bexley, at Outpatients Clinics and at Castlewood Day Hospital, Shooters Hill, S.E.18.

Hospital recognised for D.P.M., Clinical Instruction, Tutorials in Psychology given and facilities exist for attending D.P.M. courses.

Applications, giving two referees, to Physician Superintendent within ten days.

THE ROYAL MARSDEN HOSPITAL, SURREY BRANCH, DOWNS ROAD, SUTTON, SURREY.

Applications are invited for the post of **Resident Senior House Officer** (with surgical duties). This is a post-graduate teaching Hospital—a radiotherapy centre with high energy apparatus and 99 beds. Application forms can be obtained from The Administrator, to whom they should be returned as soon as possible.

NURSING NEWS

Entered:
Sister B. Sweet to Victoria.
Sister A. L. Packer to The Evelina Hospital.
Sister H. Broadbent to The Evelina Hospital.

PERSONAL

Young Guy's man requires assistant in friendly practice 55 miles north of London. New equipment and plenty of work. Excellent remuneration on high percentage basis for young colleague practising good dentistry. Box No. 35.

East Sussex Coast. Assistant required, January, 1966, with definite view to a permanent Associateship. Modern premises and superb surgery with all new equipment. Every type of work available. Hygienist and first-class staff, including large Laboratory. Genuine opportunity for young man wishing to settle. Enquiries welcomed from students qualifying this Christmas.

Unfurnished, new two-bedroom luxury flat. Garage, orchard, garden. Quiet. Forest Hill 4098.

CHANGE OF ADDRESS

Dr. D. K. C. Cooper, Department of Anatomy, Harvard Medical School, 25, Shattuck Street, Boston 15, Massachusetts, U.S.A.

EDITORS P. BOWDEN AND A. E. RAYNES
SPORTS CORRESPONDENT A. PROCTER
FORTNIGHTLY TWO SHILLINGS VOLUME 79 NUMBER 2014

GUY'S HOSPITAL GAZETTE

PASSIM

If not, answer 'No'

The rituals involved in entering for the London final M.B., B.S., examinations make the civil service look like efficient amateurs working in a paper shortage.

The candidate is presented with a thick sheaf of different coloured forms, labels and envelopes. There are delicate questions about one's name, age, sex and a few other things, usually in triplicate, all to be signed and counter-signed by anyone with a rubber stamp, a few grey hairs and time to spare. The envelopes, all to be self-addressed, convey to the uninitiated written instructions concerning where to affix the stamp. Of course, the whole thing could not be complete without a size K registered envelope. This is obtainable at any post office, except in the weeks prior to London University examinations, when the demand for this model is so great that the G.P.O. size K registered envelope production line cannot cope and invariably breaks down.

One can only assume that this is in itself a form of underhand examination by which Senate House manages to select only those candidates who can read and are obsessional enough to complete this task. It also justifies the enormous size of Senate House in which the officials of the university manage to lose themselves and under whose name they prefer to remain anonymous.

For his fortitude the successful applicant will receive an admission card for the examination of his choice, with instructions stating that he "must not take anything from the examination room" and that "bottles of ink must be deposited with the Invigilator". It would appear that the University must have been embarrassed by an examination hall having been stripped of its furniture and hangings after an examination or a time when a quantity of T.N.T. was smuggled into a hall in an ink bottle and detonated, causing some distraction to the other candidates.

Having taken the examination, the candidate can rest assured that the results will be adequately published; in fact, in three separate places on three different occasions. Should the candidate have passed the examination then it is only a matter of several months before he is invited to be presented to the Chancellor of the University at the Albert Hall on either one of two occasions. This necessitates a few more sheets of instructions from Senate House on conduct at the hall. One particular slip of paper, with worried red print, implores the graduate to keep moving at the ceremony and implies that should he

stop, faint or suffer an apoplectic attack then the Chancellor is likely to be stampeded by a mob of one and a half thousand people, all robed and hooded. The political consequences would be immense.

Of course, the graduate doesn't actually receive his degree at this ceremony; it is sent by post a little later.

If all this is necessary, then the naïve simplicity of the Conjoint exam. with its single application form and immediate results can only be regarded with suspicion.

Intake '65

We welcome the new students to Guy's, their fresh faces stir old bones. They are recognisable not because they are unknown but because of their air of purpose, they tend to have new watch straps, brief cases and ties with dazzling gold bands, most of all they look healthy. They stand in the medical school reading the inscriptions on the busts inquiringly and wondering where their's will stand. Their eager eyes set in a not yet sallowed face peer expectantly at the Spit menu, over the months there will be a metamorphosis of expression. Guy's and Dolls is doing a roaring trade and there's rumour that Matthew Arnold has taken on extra staff. They have so much to tell each other and whole grants to spend. At lunch-time the local inns are full. Bank managers welcome new accounts with relish and apprehension. Dissection instruments, skeletons, books and not-so-white coats which are bound to get one through, the old lags are busy selling what they can no longer afford to own.

They will notice that *Pulse* will appear on occasion full of groans that it's not full of talent. It will try to wake them from their apathy, why not sleep on? One gets the impression that there are many shepherds without sheep at Guy's. It will continue to pass spotty comments on independence and support rather as a snotty-nosed child wondering why no one will come out to play.

GUY'S DIARY

OCTOBER

EXHIBITION		Bone Tumours.
19th T.	4.30	Student Medical Education Committee Meeting, North Common Room.
21st Th.	1.00	Professor POLANI. Clinical Lecture. *"Chromosome Aids to Clinical Problems."*
21st Th.	4.30	Physiological Society: Miss Y. F. S. Glen. *"Ancient Egyptian Medicine."* Chairman: Dr. Moynahan. Physiology Theatre.
21st Th.	5.00	Neurosurgical Round conducted by Mr. Peter Schurr in the Clinical Theatre.
23rd S.	10.00	Clinico-Pathological Meeting. Clinical Theatre.
26th T.	1.00	Professor ATKINS. Clinical Lecture, *"Head Injuries."*
28th Th.	1.00	Mr. BLACKBURN. Clinical Lecture, *"Management of Thyrotoxicosis."*
28th Th.	4.30	Physiological Society: D. A. C. Barter: *"Allergies."* Chairman: Dr. Leibowitz. Physiology Theatre.
29th F.	1.00	Dr. KAUNTZE. Clinical Lecture. *"The Electrocardiogram."*

THE PLACE OF PAEDIATRICS IN THE MEDICAL SERVICES OF TOMORROW

Thomas E. Oppé, M.B., M.R.C.P., D.C.H.

The place of the medical services for children in the future depends upon the resolution of several important issues whose outcome at the present time is debatable. Perhaps the most important hinges upon the proportion of the national income which will be invested in the health services in general and of this how much will be allocated for the needs of children. The omens are not favourable for the pressing needs of defence, gambling, smoking and drinking maintain their priorities over health, education and welfare. Within the Health budget physical health precedes mental health, curative services have priority over preventive medicine and the special needs of children get scant regard. This is not surprising as the majority of our legislators are adult males more worried about their prostates and coronary arteries than their psyches or other people's children. This attitude is in line with slightly more primitive cultures where the working men of the family get served first at meals with all the choicest morsels and the women and small children get the leavings in the pot, a procedure aptly termed "Order at meals" (Sai 1960). However, I shall hopefully assume that a reasonable health service will exist in the future and that the investment value of caring properly for the nation's children will be recognised.

The next problem is the relationship between curative and preventive medicine. Traditionally in this country the two branches have been widely separated with the largest share of resources and prestige going to clinical therapeutic medicine and surgery. Paediatrics is deeply involved in this issue because the rewards of successful preventive medicine in childhood are so great both in terms of relief of suffering and shear economic advantage. A good illustration of the present unsatisfactory situation is seen in regard to the supervision of the health of the infant and pre-school child. A conscientious mother takes her baby to the Child Welfare Clinic for well-baby care and preventive immunisations and is seen by a doctor who is not permitted to treat any pathological conditions which may be found, simultaneously the baby is under the care of a general practitioner who has no responsibility for prevention. It is to be hoped that the personal doctoring of the future will combine in one physician both preventive and therapeutic rôles and furthermore that the "family

doctors" of the future will have had adequate training to undertake both tasks.

Alongside the question of the part that Medicine should play in the maintenance of health and the prevention of disease lies the problem of the definition of the content of Medicine in relation to children. No one except a Christian Scientist would deny that the sick child with pneumonia presents a medical condition, but is the naughty child doing badly at school a problem for the pedagogue, the psychologist or the physician? The traditional medical preoccupations of the paediatrician; nutritional disorders, the acute infectious, congenital abnormalities, are becoming less frequent and doctors are turning toward the behavioural, emotional and learning disorders hitherto regarded as the province of other disciplines.

Perhaps the most crucial issue—at least for paediatricians—is whether there is any real justification for the provision of specialised medical services for children. It can be argued that the family doctor is and will continue to be proficient in dealing with the majority of childhood medical problems, and that children needing specialist care can get it adequately from consultants in the appropriate branch of medicine, surgery or psychiatry. The logical conclusion of the argument is that while children should be nursed in a separate physical environment from adult patients, they can be treated by the same doctors. This argument can be countered by the fact that the pathology and physiology of the developing child is so radically different from the degenerating adult that even in a narrow field it is not possible for a specialist to be fully competent at treating both adults and children. Accordingly, development of the medical services should encourage the growth of such sub-specialties as paediatric cardiology, paediatric neuro-surgery, child psychiatry and their attendant investigational and research departments.

It has been stated that: "Every child born alive is entitled to the normal development of his or her physical and mental potential". The paediatric services have an important part to play in achieving this aim and my recipe for outlining the best way of accomplishing this must include my personal answers to the foregoing problems.

Each child in this country should have a personal doctor—who would be similar to the general practitioner of to-day but with a responsibility for comprehensive medical care, supervision and health education and not just a contractual obligation to treat disease. He will, I hope, be a proper "family doctor" and not a half-baked paediatrician, and he will have had a far better training in human biology, developmental medicine and social and community paediatrics than to-day's undergraduate. He will have had compulsory postgraduate experience in a children's unit and will keep himself up to date by regular reading, refresher courses and consultations with the local paediatricians and Public Health Medical Officers.

Every large town will have a District Medical Centre which will provide facilities for in-patient treatment, out-patient consultations and postgraduate education. These facilities for children will be separate from adults and the out-patients will include clinics for child psychiatry, and the assessment of handicapped children as well as the conventional medical and surgical clinics. The present peripheral and isolated welfare clinics, and child guidance clinics will disappear. Children acutely ill but who do not need hospitalisation will be nursed at home with the assistance of a Home Care Service run from the District Medical Centre and this will reduce the need both for hospitalisation and the provision of uneconomic and inefficient in-patient children's units in small local hospitals.

The District Medical Centre is unlikely to have sufficient numbers of children with rare or complex complaints to justify a staff of paediatric sub-specialists, but all departments, clinical and laboratory, should have some personnel interested and trained in the special needs of children.

For the children with the most difficult diagnostic and therapeutic problems there should be a few teaching centres which would contain within the University Medical Centre either a large children's hospital or a comprehensive children's unit in the main teaching general hospital. At these departments there would be a full staff of exclusively paediatric specialists in all branches of Medicine and it is in such centres that major clinical and laboratory research would be done.

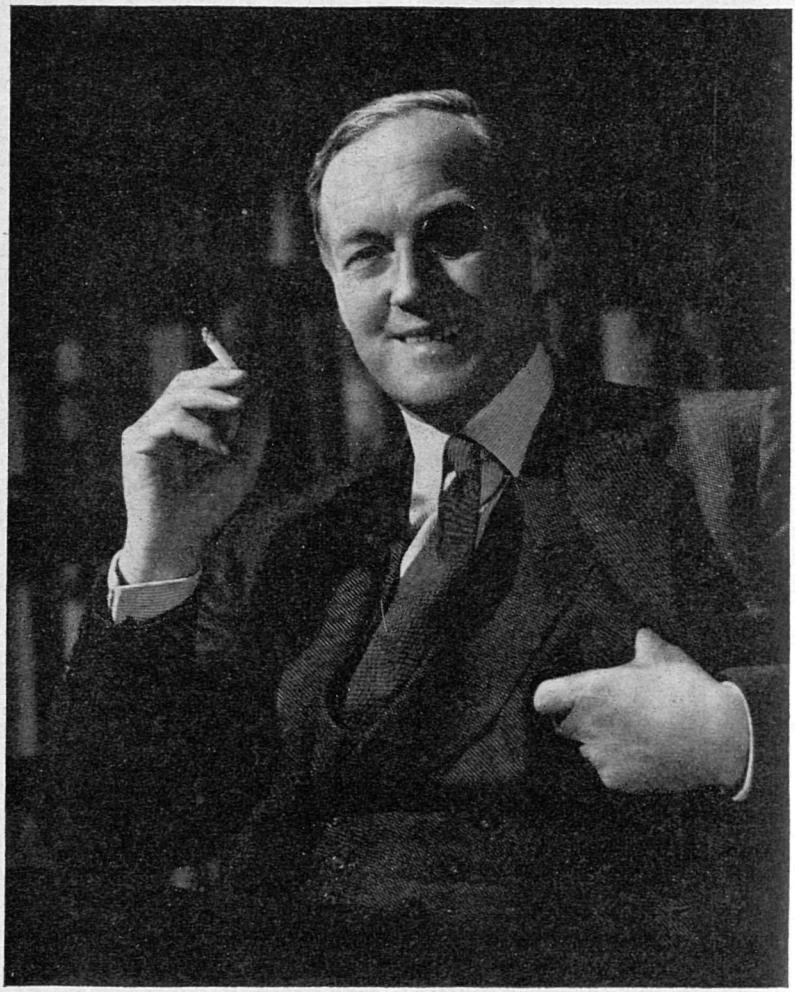
Just as the family doctor will take on the responsibility for individual preventive medicine so should the District and Teaching Medical Centres become responsible for social and community medicine in their area. This would, of course, not reduce the position of the Medical Officer of Health but bring him and his department into closer contact with the other medical services.

It must not be forgotten that a large number of children are in institutional care because of severe chronic mental and physical handicap, and that many others, although not institutionalised, are in need of special medical, educational and welfare services. The organisation of these facilities and their integration with the non-medical services is likely to prove an increasing problem as the community becomes more aware of the needs of these children and means to help them become available. There is nothing inherently impossible in providing these within the framework outlined, provided that all doctors realise their responsibilities for this type of problem.

REFERENCE

Sai, F. T. (1960) Introducing new foods against protein deficiency. Nutrition Reviews, 18, 353.

SIR ROWAN BOLAND
C.B.E., M.D., F.R.C.P.



The retirement of Sir Rowan Boland from the office of Dean of the Medical and Dental Schools means the loss to Guy's of an outstandingly able Dean, and of the day-to-day services of a man of character and determination exceptional even in the colourful history of that institution.

Boland came to Guy's as a Medical Student in 1915, when he was seventeen years old. At that time there was heavy fighting in the First World War, and after a few months the young man felt it his duty to give up his studies and volunteer for combatant service. He went to Flanders as a Second Lieutenant in the Rifle Brigade, and was seriously wounded. After prolonged treatment in military hospitals, he was passed fit for active service and returned to the fighting line. Wounded again, this time so severely that there was no prospect of further service in that war, he was invalided out of the Army and returned to his medical studies at Guy's. The next interruption was caused by an attack of pulmonary tuberculosis which in those days necessitated prolonged rest and complete inactivity. After one relapse he made a lasting recovery, and academic progress was rapid until he was bowled over by acute toxic nephritis. This was associated with trouble in one of his numerous war wounds, and it was cured by the removal of several inches of khaki trouser-cloth from the bone marrow of a fractured femur. These setbacks did nothing to impair his enthusiasm for work, and he made a vivid impression on those of us who had the enjoyable experience of acting as his clinical teachers.

Personal experience of pulmonary disease inclined his attention to that branch of medicine, and even before qualification he attached himself to the Tuberculosis Department, later renamed the Department for Diseases of the Chest.

Treatment of tuberculosis in those days, though often successful, was tedious and prolonged, and required cordial co-operation between patient and physician over periods of years. Boland, with his lively interest in individuals, and his ardour in defending the unfortunate against unkind strokes of fate, became a pillar of strength in the Department, with a loyal following of patients and students. In due course he became First Assistant and ultimately Head of the Department.

At the same time he was a stimulating teacher of General Medicine, and early showed a flair for administration when reorganising the work of Preclinical Tutor. Appointed Assistant Physician in 1934, he had five busy peace-time years before war struck again.

With superb presumption he presented his battle-scarred physique to the military authority and demanded to be passed fit for active service again. He quickly made his mark, was promoted Brigadier and appointed consulting physician to Allied Force Headquarters, North Africa, Sicily, Italy and Greece. He earned gratitude for indefatigable service to sick and wounded of many nations, both friend

and foe, and was mentioned in Despatches and given decorations by other Governments as well as our own.

After the war he returned to his clinical work at Guy's and made notable contributions to the study of respiratory diseases, including asthma.

He has been an exceptionally successful Dean in a time of revolutionary changes in the organisation and financing of medical education. He has been Dean of the Faculty of the University of London and has been Chairman of important committees on civil education and military staffing: he is a member of the General Medical Council.

Guy's is wise and fortunate in having Lady Boland on the staff as the first and most distinguished of official advisers on interior decoration.

Sir Rowan's experience and advice will still be available and his active association with Guy's will not be allowed to lapse for a long time.

One cannot imagine E. R. Boland sitting back in idleness: may he have health and happiness in his so-called retirement.

GEOFFREY MARSHALL,
K.C.V.O., C.B.E., M.D., F.R.C.P.

REVIEWS

BIOCHEMISTRY.

By S. P. Datta and J. H. Ottaway. Concise Medical Textbooks, Bailliere, Tindall and Cassell, 1965. Pp. 360. *Price* 21/-.

This, in the authors' words, is " a successor to the Sixth Edition of *Aids to Biochemistry*," which has already been favourably reviewed in the *Gazette*. The sale of *Aids* has encouraged an expanded version which differs by having a chapter on techniques and extra diagrams of metabolic pathways and other material. In spite of its title, it cannot be compared in thoroughness with the expensive thick American textbook, but it does contain a great deal of material that will be useful, especially to medical students. One of the authors is well known for his work on dissociation constants of biological phosphate esters, and it is therefore surprising that he has allowed the expression "H_3PO_4" and its organic equivalents as part of the description of reactions supposed to occur at biological pH. There is also some confusion in the use of $NADH_2$ instead of NADH for the reduced cotenzyme. Of course the authors know very well that the use of such formulae is very naughty in a textbook intended for teaching purposes, and one may only hope that the student reader will share their insight. In other ways, too, the book is carelessly written and the text needs a detailed revision, especially to ensure the consistent use of symbols (such as P for the phosphate group). A general criticism that can be brought against this type of textbook is that it is neither a very concise summary nor a fully comprehensive exposition. If you do not feel like buying a larger textbook, and especially since this will soon become out of date anyway, you could do a lot worse than have a copy of Datta and Ottaway. For the research worker and general reader, the book will be valued chiefly for the formulae, lists of normal values in human body fluids, details of radioactive isotopes and other reference material readily available in the text.

G. A. D. HASLEWOOD.

A NEW LOOK AT MEDICAL EDUCATION.

J. Anderson and F. J. Roberts. Pitman Medical, London 1965, pp. 81. *Price* 7*s*. 6*d*.

This vigorous and readable book is full of excellent general and specific comment on medical education in Britain as it is and as it might be. Professor John Anderson, the professor of medicine at King's, and Dr. Roberts, of Bristol, look at the medical profession's place in society past, present and future. They look forward to first-class health centres as the pivot of medical practice. They look at the Medical School and suggest that the medical schools should charge students realistic fees and thereby gain considerable independence of the U.G.C. (The fees would be met by increased local grants to students). A basic medical course of 4 years is envisaged with a 2-year graduate training course.

The out-of-date nature of medical teaching at present is thoughtfully analysed. The aims of the medical school should be much more clearly thought out and announced to students and teachers alike. The authors refer to two theories of learning. The field theory (of Wertheimer and Lewin) "stresses the importance of insight in giving rise to behaviour changes in response to significant sensory experiences". I wish they had expounded this in greater detail. The other important concept, the association or conditioning theory, "emphasises the importance of establishing a relationship between a given stimulus and the appropriate response". It is, of course, the immediate reward that makes the well designed teaching machine so successful.

The quotation from Whitehead and the comment on it are indeed welcome. "He said there are three stages of learning; the stage of romance, the stage of precision and the stage of generalisation. Too often the teacher plunges into the stage of precise information leaving the student to find his own inspiration. Most of the multitudes of curriculum designers seem to ignore Whitehead's first and last stages of learning". Certainly, if medicine is to be an academic training, i.e. to give capacity to cope with previously unmet problems, rather than purveying a set of rule-of-thumb "one symptom, one cause, one treatment" responses, there should be clearer exposition of the philosophy of medical thinking. By this I mean how a biological or medical problem is to be tackled, what is "cause", what is a "diagnosis" and so on.

The chapter on the curriculum emphasises that teaching could profitably be mainly in the (new style) health centres rather than in the highly specialised hospital unit. There is a very welcome appeal to try out new patterns of teaching. A department of medical education is needed in each medical school to be the executive arms of the curriculum and to conduct courses on teaching and learning for the junior medical staff and undertake research in medical education.

The need to measure achievement in learning and the place of examinations and other tests is very well discussed with many practical ideas.

This (otherwise) excellent book has one peculiarity. Although the majority of doctors will have to deal to some extent with children, no provision is made for teaching the undergraduate student about the child and his special needs. Yet the diagnosis and management of ill children is very different from those of adults and the potentialities of paediatrics are very different. It is because paediatrics has its special interests in growth, prevention, the comprehensive approach and measurement, that it can make such a valuable contribution to the total education of the medical student. I hope Professor Anderson and Dr. Roberts will read the book that Dr. Michael Joseph is writing for this series.

Their book is indeed a good one; it is well written in content and in style and has fine large concepts and a number of smaller practical ideas which could profitably be put into operation without delay in almost any department of any medical school.

R. C. Mac Keith.

NATURE CONSERVATION in BRITAIN

by T. N. D. Peet

There is a long tradition of scientific observation in the field of Natural History among doctors. Quite apart from the practical uses of a subject such as Botany, the rural doctor and the rural parson were responsible for a large volume of the early collecting of specimens and observations on wild life. But now the emphasis in all branches of Natural History has swung to conservation, an effort to preserve what little remains of our wild life and countryside.

Conservation is a practical and constructive exercise: it is of little use merely to preserve a piece of land unless a policy of management is instituted which will ensure that areas preserved remain unchanged, instead of decaying. The need for conservation is acute. Our increasing population leads to a steady erosion of both agricultural and wild land. Roads, factories, power-supply lines and holiday camp sites eat into the land. Despite our damp climate we are chronically short of water, and the present battle for the water supply of Manchester from the Lake District reveals some of the conflicting interests. Perhaps the most insidious, and yet the most dangerous menace is the use of chlorinated hydro-carbon insecticidal seed-dressings, which, besides killing many forms of wild life, may yet have a toxic effect on Man. It would be foolish to hope that all these pressures on the land can be halted, but they can be diverted and channelled in an attempt to preserve something of what is left of our wild life and its habitats.

The roots of the conservation movement are the County Naturalists' Trusts. Nearly every county in the country has a trust, which local people can join, and which are responsible for sites and fauna within their own areas. The local county trust can purchase sites with a long-term loan from a parent body, the Society for the Promotion of Nature Preserves. In fact, many sites are protected by mutual agreement between landowners and the local trust, and do not need purchasing. Large projects need handling by a national body, and the present Operation Neptune, designed to preserve what is left of our coastline, is being mounted by the National Trust. Nearly all the work at county level is voluntary, but close liaison is maintained with the Nature conservancy (Government-run, and responsible for much research), the Forestry Commission (who are landowners on an enormous scale) and other relatively specialised groups such as the Royal Society for the Protection of Birds. Money is a constant need, and subscriptions, local appeals and generous donations from the World Wild Life fund, the Nuffield and Pilgrim Trusts have all provided funds.

What can a county trust accomplish? A good example is the oldest of the trusts, that of Norfolk. Founded in 1926, it now owns over 3,400 acres of land, and administers another 4,000 in conjunction with the National Trust. Some examples will illustrate how intense

commercial pressures on the land and coast of Norfolk are resisted. On the Broads, while allowing for their full use for boating and fishing, active conservation of rare plants such as the Marsh Sow-Thistle and *Najas marina;* rare insects such as the Small Marsh Footman Moth (unknown elsewhere in the British Isles); and the preservation of the breeding grounds of rare birds such as the Bittern and Bearded Tit, are a vital part of the Trusts' work. Inland, on the Breck around Thetford and Tuddenham, the last remaining areas of open, dry, flinty ground have been saved from farming and the Forestry Commission, to ensure the survival of rare plants, insects, and birds such as the Stone Curlew. On the coast, large areas have been set aside from wild fowling, and bird migration studies go on at Scolt and Cley, two of the best sites for watching migrants in England.

Although Norfolk is the oldest trust, many other counties are acquiring sites and taking part in land management. Possibly the smallest reserve is the site of a rare buttercup in Gloucestershire. The County Trusts have managed to control roadside weed spraying, and have recommended cutting instead. Chalk-pit excavations, gravel quarrying, reservoir construction all represent potential threats to local ecology, and if thought necessary, local trusts are represented at Government inquiries into planning permission and development projects.

I would not like to give the impression that the trusts exist merely as obstructions to all development of land and natural resources. But where there exists a case for the preservation and conservation of rare or interesting wild life or habitats, the county trusts will fight development. People with an interest in the conservation of the natural resources of these islands would do well to lend their support to the County Naturalists' Trusts.

CORRESPONDENCE

Sir Rowan Boland

SIR,—Passim has delivered itself well, indifferently and badly for a very long time indeed. But never, in the 40 years of my memory of it, has it failed so ignominiously and publicly to speak for Guy's as it has done in the eleven miserable lines with which it pays a valedictory "tribute" to that very great Guy's man Boland—in the view of most, the greatest Dean the School is ever likely to have.

This, Mr. Editor, was a disgraceful dereliction of duty you owed to both the *Gazette* and to Guy's. Come now, remember Oscar Wilde: "On an occasion of this kind it becomes more than a moral duty to speak one's mind. It becomes a pleasure."

Yours, etc.,

KEITH SIMPSON

Department of Forensic Medicine,
Guy's Hospital, S.E.1.

"Guys Hospital"

SIR,—I was pleased to read that in your last edition's Passim, comment was made about the notices in St. Thomas Street and the precincts of the Hospital. To those people who do not know the very fine traditions of Guy's, to read these notices on entering does not inspire one with confidence.

It may be of some slight consolation to know that the Corporation of the City of London have made an even worse blunder in Lombard Street, where a plaque informs the passer-by that it is the "Site of Lloyds Coffee House." Obviously the Corporation have muddled up Edward Lloyd, of Lloyd's of London, with Lloyds Bank!

Yours, etc.,

F. J. PITTS.

7, De Montfort Road,
Streatham, S.W.16.

Diverticula . . . e

SIR,—I feel it is a great pity that in the article by E. N. Wardle in your issue of the 18th September, 1965, we find the plural of diverticulum spelt "diverticulae." I have heard this word used by students and others—surely the plural ought to be diverticula?

Yours, etc.,

N. L. ECKHOFF.

Keats' House,
Guy's Hospital, S.E.1.

Educational Sub-Committee of the Dental Society

SIR,—May we, through your columns, thank the dental students and staff who have co-operated in the duplicating, circulating and completing of our questionnaire. This was distributed in September to all clinical dental students by the Educational Sub-Committee of the Dental Society. The questions were designed to investigate student opinion upon Dental Education and the "New Curriculum."

We hope to present our findings to Mr. Warner by the end of October and to inform the dental students via a meeting of the Dental Society in November.

At present there are no plans for further publication on findings.

Yours, etc.,

PETER H. SIMS.
CLIVE W. TALBOT.
J. MARK WILTON.

Dental Department,
8th October.

MISS A. L. PERKINS. AN APPRECIATION.

There must be hundreds of Guy's nurses, men and friends, who have known Miss Perkins since she commenced her training at Guy's nearly forty years ago. They will, I am sure, be thinking of her on this glorious October day, as she leaves her beloved hospital and drives down to her charming home in the attractive village of Steyning, where a warm welcome awaits her.

As was evident on Monday last, she was surrounded by the love of her many friends—past and present—members of the medical and nursing staff, Governors, and those with whom she had worked in close contact over the years, who met to pay tribute to her outstanding and devoted service to Guy's, at the party which the Governors were so pleased to give for her.

Those present remembered her as a first class nurse, Ward Sister, Night Superintendent and Administrator; they also remembered that which she had taught them by example and precept, for to her the motto of Guy's was the meaning of life.

I well remember how delighted we were when Miss Perkins returned from the wilds of Cornwall as the First Assistant Matron, with special responsibility for the allocation of Student Nurses. They felt they had a friend at court, someone who was genuinely interested in them, and with whom they could discuss their difficulties; a person of the highest principles and one with a warm heart and a sense of humour.

It was also a great joy to me to have as a member of the Senior Staff someone who knew so many retired members of staff, Governors and their wives, and members of the Guy's Hospital Nurses' League, for this ensured a welcome wherever they might be in the hospital.

In recent years I think one of the things which Miss Perkins has most enjoyed is the opportunity she has had to interview the daughters of Guy's men and women who were being considered for training in one or other of the Women's Training Schools. Needless to say, the parents were equally as delighted to see Polly P!

Finally, I would like to pay a personal tribute to Miss Perkins for her loyal support and help to me during the years we worked together in the Matron's Office; years during which the face of Guy's was changing, but not the traditions, as long as she was there to help us all to maintain them.

Guy's loss is certainly Steyning's gain—may she have very many happy years ahead, and may she enjoy every blessing which she so richly deserves.

J.R.

Guy's Hospital Physiological Society

This term sees the start of a new programme of meetings of the Guy's Hospital Physiological Society. These will be held on each Thursday of term at 4.30 p.m. in the Physiology theatre. Papers on a variety of topics of physiological interest will be read by members before the society and there will be an opportunity to discuss these during the meeting. The society meets for tea at 4.15 p.m. before each meeting in the B.Sc. Physiology laboratory which is to the left of the top entrance of the Physiology theatre. Freshers are especially welcome to our meetings, and though the society is mainly for 1st, 2nd and 3rd year students, visitors from all departments of the Hospital will, I hope, find our meetings of interest.

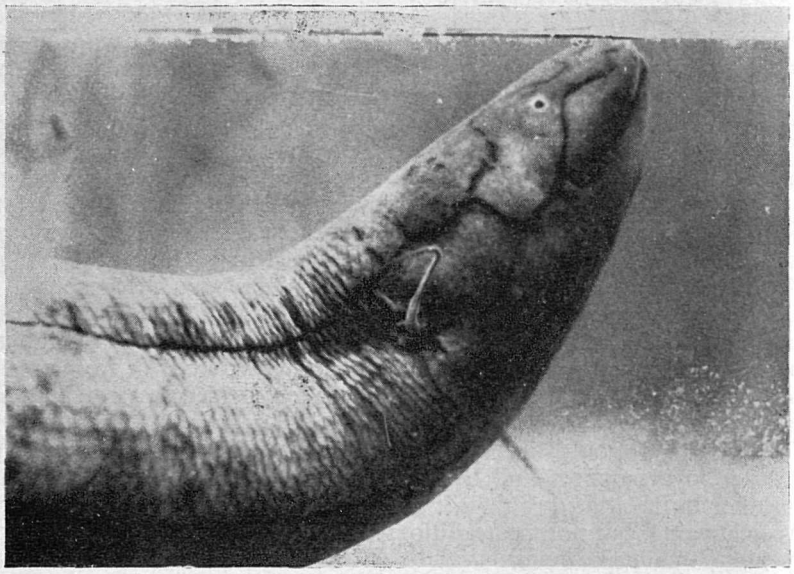
A VISIT TO THE LOWER AMAZON

or

Up the Igapo without a Paddle

By E. C. Tatchell

At tea-time one afternoon in the summer of 1963, mention was made of the discoveries of the late Professor Graham Kerr and his expeditions to South America some seventy years ago. One of the most interesting animals observed and collected was the South American lungfish, *Lepidosiren paradoxa*, an air breathing fish. Professor Foxon went on to talk about the specimens of this fish which had been kept in Professor Kerr's department for many years, and of the difficulty experienced these days in acquiring living lungfish from South America.



Immediately after tea some members of the Biology Department asked one another the question, " Why not go and get some?" During the next week feverish investigations were made in order to answer some other questions: Where? How? For how long? and perhaps most important of all, How much will it cost? Finally the following proposals were made: that Mr. I. R. Bishop should lead an expedition to the Lower Amazon region, that the members of the expedition should fly to Manaus, a town 1,000 miles up the Amazon, and stay in the area for three months from the beginning of July, 1964, to the end of September, and finally that the estimated cost was £3,500. As the idea seemed promising, further investigations were carried out into the feasibility of the plan.

During the next few months with much encouragement and advice from Hospital and University authorities, the expedition took shape. There were to be four members, I. R. Bishop (Leader), whose main interest was in the mammals of the area, E. C. Tatchell (Equipment), with a special interest in the rivers and lakes which would be encountered, D. Walliker, a parasitologist, and Dr. J. C. Garnham, who was to investigate some medical problems and look after the health of the expedition. Dr. Garnham was also the firearms expert and gathered together a small arsenal which at one stage of the expedition provoked one area military commander to ask if we intended to start a revolution! Thus, from our original intention to collect some lungfish and have a look at its environment, we had extended the field of the expedition to include general studies on the aquatic and terrestrial fauna, their parasites and some medical problems including a search for a reported chloroquin resistant strain of the malaria parasite, *Plasmodium falciparum*.

By the beginning of June, 1964, we had collected sufficient money to buy the required equipment, our air passages and to cover expenses in Brazil. Our equipment after one or two hair-raising difficulties of a bureaucratic nature had been shipped from Liverpool and was expected to arrive in Manaus by the 1st of July. It had been decided that I.R.B. should leave a fortnight ahead of the main party and should prepare things in Brazil so that the expedition could get under way promptly on its arrival. However, the pattern of future events was foreshadowed by his plane making an unscheduled stop on a small island in the Atlantic, of which the main impression Bishop received was of squads of soldiers rushing around with machine guns, however, his delay was only a short one and from there he made an uneventful journey to Manaus.

Back in England the expedition was poised for take off, but for the delay in delivery of some electronic gadgetry for measurement of oxygen level and temperature in fresh water which was to be flown out with the main party. Because of its delicacy this apparatus was to be the Equipment Officer's main worry for the journey.

Although our take off from London Airport was delayed, our aircraft made only its scheduled stop at Lisbon before touching down at our destination Recife. Here was our first contact with Brazilian customs and armed as we were with official documents and letters of introduction we felt that there should be no difficulties. Indeed, it was quite easy to convince the authorities that, although undoubtedly mad, we represented no danger to the state even though it had gone through one of its periodic revolutions some months previously. The doubts as to our sanity rested unfortunately on the efforts of the Equipment Officer, who, on seeing the way in which packing cases were being broken open, rushed to inform the Customs' officials that his contained scientific equipment that was very delicate. Unfortunately, the conversation had to be carried out in Portuguese, and the word for delicate is "fragil", not "delicado", this latter word made up for the occasion means "polite". Once through the customs we were to experience a fairly common Brazilian occurrence, the taxi we

had hired to take us into Recife broke down, but after further language difficulties we succeeded in getting a meal and returned to the airport for the next stage of the journey.

Fortunately our flight from Recife up the coast of Brazil to Belem at the mouth of the Amazon was accomplished in a propellor 'plane which flew low and slow enough for us to see something of the Brazilian countryside, low scrub and grassland in this part of Brazil.

We arrived in Belem late in the night and were taken from the airport to an hotel, where we spent the night. Our 'plane was due to take off at 7 a.m. the next morning, and we had to get to the airport at 6 a.m. To our surprise, the taxi called at the hotel at 5 a.m., although the journey to the airport took only twenty minutes. However, when the taxi got a puncture and had to change a wheel, we understood the reason for our early start. We arrived at the airport with some ten minutes to spare and sat down to wait for our flight to be called, ten hours later we were still waiting. Shortly after four in the afternoon we climbed aboard a DC4 aircraft and took off for the last leg of the journey. As we circled up over the skyscrapered city of Belem, one of our engines stopped, so we circled down again and landed. One hour later we were informed that the flight would be postponed until the next day as night flying over the Amazon Basin was dangerous. The next morning the same procedure was followed except that the taxi did not break down and the 'plane took off roughly on time.

The journey from Belem to Manaus was broken only at Santarem, a riverside town some five hundred miles up the Amazon, and provided an excellent introduction to the area we had come to see. The vast winding river and unbroken stretches of the rain-forest covered Amazon Basin made a fascinating panorama, and just as we were

about to land at Manaus, we circled over the famous " Encontra des Aguas", the confluence of the dark waters of the Rio Negro and the silt-laden yellow Rio Solimoes. The waters of these two rivers do not mix readily, so that the line of demarcation is quite distinct for some miles below their junction.

As we walked off the tarmac into the airport buildings, we saw Bishop propping up one of the pillars in the concourse, perhaps, quite literally, as later a large section of the ceiling descended with a deafening crash! Bishop had been well received by both our contacts in Manaus. Dr. Djalma Batista, the Director of the Instituto Nacional de Pesquisas de Amazonia (I.N.P.A.) had offered his full co-operation with the expedition, and throughout our stay made efforts to supply all possible requirements for the success of our operations. He also provided us with accommodation and allowed us to use the Institute's launch and crew for our voyages up the Rio Negro and Rio Solimoes. We had also written to Mr. W. Denton, the British Vice-Consul and Manager of the Manaus branch of the Bank of London and South America, and his help in translation and the overcoming of administrative difficulties was to be invaluable during the two months we were there.

Our plans, so confidently put forward in England, now had to be radically altered, the ship carrying our equipment had been delayed, and it was nearly three weeks before it arrived. Mr. Denton introduced the expedition to a Dr. Rodolpho Friburgo, a civil engineer and keen amateur naturalist who was in charge of the construction of a road joining Manaus and Itacoatiara, a smaller town further down the Rio Amazonas. The road then extended some 130 kms. north-east of Manaus. One hundred and five kms. along this road, Dr. Friburgo had built a camp in which he and his wife lived, and they invited us to stay with them until our equipment arrived. The ten days or so that we spent at this camp were most instructive, and the party learnt much from Dr. Friburgo and from Mozarth, a technician lent to us by I.N.P.A., on precautions to be taken in the forest. We were also able to make collections of birds, mammals and amphibians using equipment loaned to us by I.N.P.A. We also made some progress with our Portuguese, as only Dr. Friburgo spoke English.

Mozarth proved to be a good hunter and brought down a deer with his shotgun, which after being measured, was photographed, and having had samples removed was a welcome addition to the meal-table, as was a tapir shot by some local hunters. This animal provides meat not unlike beef in texture.

On our return to Manaus and whilst we were struggling with the complexities of the customs office in an effort to get our equipment released, Mr. Denton and his wife introduced us to many people who had first-hand knowledge of the area and whose advice was most valuable.

By the 25th of July all was ready and we set off up the Rio Negro to the junction of this river with the Rio Branco some 300 km. north of Manaus. The rainy season had ended only shortly before the arrival

of the expedition, and the level of the rivers was very high, often the water extended far into the forest, driving land animals away from the banks of the rivers. Consequently we saw few animals and our attention was focused on the river. Baiting our fishing hooks with fresh meat, we were able to catch a number of species of fish, including the notorious piranha, well known for its savage attacks on men and animals which venture into the rivers of this area. We tied up on the bank of the Rio Branco just above its point of confluence with the Rio Negro and spent some days collecting and observing the animals to be found, mainly fish, amphibia and reptiles. We were also able to film the swarms of butterflies which came to the clearing where our boat was tied up.

On the first afternoon of our visit reports of ducks on a nearby lake tempted our doctor to go off in search of some for the cooking pot. He departed with a local guide in a canoe and disappeared into the flooded forest or to give it its Brazilian name, the *igapo*. When night fell we began to wonder if we had lost our medical officer. Some distant shots were replied to and we succeeded in persuading some locals to set off in search of the two with the aid of dogs. Some time later they were located and returned, our doctor somewhat indignant as the "Guide" had become lost soon after nightfall, and as a doctor, J.C.G., had not relished the thought of spending the night in the mosquito-infested igapo without net or insect repellent. The incident was the second of its kind and we decided in future to establish a S.O.S. system of gunshots. This we employed with success a few days later on a pig hunt. It was not so much that the locals became permanently lost in the forest, but that their date of return could not be forecast.

On our return to Manaus we rapidly re-stocked the launch with food and supplies and set off up the Rio Solimoes to a small village some 250 km. from Manaus. The banks of the Rio Solimoes are far more populated than those of the Rio Negro, but our stay in Codajaz was far more productive in numbers of animals captured. We were most ably assisted here by a group of hunters who brought in a daily catch of mammals and reptiles. The small boys of the village were soon organised into an efficient machine for the collection of smaller animals, and they also succeeded in capturing some sloths and alligators. These collections were supervised by Bishop and Walliker, whilst Tatchell and Garnham made trips to nearby lakes to study their fresh water biology and hydrology. Dr. Garnham was also able with the help of local authorities to undertake some clinical helminthology studies. The last port of our stay in Codajaz was marred by the illness of David Walliker, who, however, recovered after a few days in spite of our prolonged search for malaria parasites in his blood. On our return to Manaus he and Dr. Garnham returned to the camp at 105 km., whilst Bishop and Tatchell stayed in Manaus to arrange for our passage by steamer down to Belem.

This voyage was most interesting and the three-day stop at Itaoratiara, whilst Brazil nuts were loaded, enabled us to compare conditions

in a small town with those we had seen in Codajaz. Our arrival in Belem on the 5th of September was enlivened by the imminence of Independence Day, which was celebrated with much gusto on the 7th. However, as we had travelled from Manaus in a British ship, the customs authorities held that the party was seeking to re-enter Brazil. More frustrating was their refusal to recognise the validity of our documents and the establishment of our bona fides took a fortnight, during which time our equipment was impounded.

During the stay in Belem the party was almost entirely dependent on borrowed equipment provided by Dr. Orlando Costa, of the Evandro Chagas Institute, and by Dr. Dalcy Albuquerque, of the Goeldi Museum, who also provided us with excellent accommodation within the Zoological Gardens attached to the Museum. The kindness of the staffs of these institutes in their assistance and provision for entertainments more than counteracted the disagreeable impression raised by the obduracy of the customs authorities.

Dr. Garnham, with the aid of Dr. Lins of the Evandro Chagas Institute, was able to investigate the possibility of the incidence of resistent malaria, although no definite conclusions could be reached. Walliker was able to continue his parasitological investigations at the Belem Virus Laboratory, where animals are captured from the Utinga Forest. For Bishop and Tatchell the discovery of Lepidosiren in a shanty town suburb of Belem was most exciting. The fish were found in a shallow ditch, running between two rows of shacks, used as a repository for household refuse and consequently somewhat foul and, as shown by the oxygen recording apparatus, of negligible oxygen content. Some fifteen lungfish were captured and twelve of them were sent by air to this country, and most of them are alive and healthy in aquaria in the Biology Department.

Work on these animals and on the specimens and data collected is still progressing. However, the information gathered on this expedition can only be regarded as the foundation for further work on later trips. The members of the expedition hope that they or others will be abe to make more and longer expeditions to this most interesting area. The assurance of great assistance and co-operation from the scientific and medical authorities in the area will make the tasks of organisation and execution much easier.

The members of the expedition would wish to express their thanks to all concerned with the expedition, to the many individuals, commercial companies and public bodies who by their financial support and other aid enabled this journey to be undertaken. Among the public bodies the following should be especially mentioned: the Zoological Society of London, the Medical Research Council, and particularly the Wellcome Trust which by a generous guarantee made the project possible.

SPORT

DIARY

OCTOBER

Oct. 16.—Rugby Football—Bedford. Away.
Association Football—King's. At home.
Hockey—Romford. Away.

,, 19.—Squash—Lensbury S.R.C. At home.

,, 20.—Association Football—Sir John Cass College. At home.

,, 21.—Squash—O. Johnians. At home.

,, 23.—Rugby Football—Cheltenham. Away.
Association Football—Birkbeck College. At home.
Hockey—H.A.C. At home.

BLUES

P. Bennet—Half blue for Hockey.

RUGBY FOOTBALL

Although the hospital failed to win either game of Rugby in the past fortnight, the team acquitted itself well and on both occasions seemed fitter than the opponents in the last quarter of the game.

Against U.S., Portsmouth, each side scored 3 tries, Guy's converting one less try than the Services, and ran out losers 13—15. There was a slight irregularity concerning the try which we failed to convert—the kick was right in front of the poles, and although it was not a classic, it did actually go over, according to the Services' players. One touch judge raised his flag, but quickly lowered it when the other didn't raise his. The referee ruled that the kick had missed.

It does not make history if we lose to Cambridge University, because we have never beaten them. Indeed, the usual margin is twenty points. The hopeful Guy's team found Irish standoff half, M. Gibson, in his most brilliant form, and never found a way of controlling him completely. Guy's eventually lost 26—3, our points coming from a penalty by Morris.

Training sessions have been very well supported this year. Even before the preclinical term started, thirty-five people were coming, training twice a week. Last week the freshman's trials were held. They produced some good games of Rugby, and showed up some promising talent amongst the freshmen. Indeed, five players are already playing for the second team.

REPORTS AND RESULTS

HOCKEY

Two pre-season matches were arranged during September, both of which were most successful on and off the field, and will probably become permanent fixtures in the future.

On 15th September we defeated Purley 4—3 on a good pitch, and a week later we were in turn defeated by the "Haba" Club, 5—4 at H.O.P. The pitch at H.O.P. is in excellent condition, quite the best for years. The fact that 22 players were keen to play in these early fixtures may give a good indication of the enthusiasm that can be expected in the coming season.

Competition for 1st team positions promises to be very keen as new faces appear. Although only two players have left since last season, a number of people, including two freshers and an "old hand who has come out of retirement", are challenging for places, particularly amongst the halves and forwards.

Once again we hope the Club will get enough support to run a regular 5th XI fixture. It is this support that enables the Club to have block fixtures with the better known London clubs, two of whom we have fixtures with this season for the first time. The reason for wanting fixtures with the bigger clubs is that they often have far better pitches and other facilities.

We hope once again to have the use of the Peak Frean hockey pitch for some home games.

The Freshers' Trial was very successful, and our numbers have increased to the extent that a record 6th XI is a possibility. This feat has yet to be achieved in the Hospital.

Finally, a further encouraging sign for the coming season is the fact that five "Guy's men" have been selected to play for the United Hospitals in the first match of the season against "Old Felstedians".

C. A. BROOKS

GUY'S v. SOUTH SAXONS

Away Saturday, 9th October, 1965

Result: draw 3—3

The start of the official season is always looked forward to with great keenness, and more so this year, since not only had the Club played more practice matches than usual, but several players had undertaken considerably more pre-season training than has been customary. It was with great hopes, therefore, that the first two elevens set off to Hastings.

The game started at a fast pace, and it was soon evident that Guy's were not going to have everything their own way. The fast moving South Saxons' forwards gave the defence endless trouble, and it was no surprise to find them two goals up after twenty minutes. The Guy's forwards could not settle down at all, the start of attacking moves being constantly broken up by an excellent opposing centre-half. Shortly after being 2—0 down, Bennett had the ball in the net from the back of the circle, but a goal was disallowed under the re-instituted "sticks" rule. Just before half-time, after a mêlee in the goalmouth, Cripps came in very smartly to push the ball home and make the score 2—1. The second half saw little change in the pattern of the game, although the defence was more cohesive. However, it was not long before the opposition made the score 3—1, but the arrears were soon reduced by a brilliant solo effort. Picking the ball up on the "25" line, Cripps completely wrong-footed the defence, took the ball into the circle, his angled shot rebounding off the 'keeper before he finally put the ball home. With five minutes to go, after a period of sustained Guy's pressure, the scores were levelled. A cross from the left was not properly cleared by the Saxons' defence, and three defenders waited for each other to do something about it as Carruthers walked the ball into the net.

Crafts did endless good work in defence, and there were encouraging displays by the two freshmen, Pearson and Horrocks, but otherwise a disappointing performance.

Team: S. Rear; R. Kendrick, M. Horrocks; J. Crafts, C. Brooks, R. Jenkins; R. Carruthers, S. Cripps, M. Appleby, P. Bennett, C. Pearson.

RICHARD CARRUTHERS

GOLF

20th September, 1965

Fair stood the equinoctial gales for Woodbridge and the Memorial Registrar Golf Tourney, held in loving memory of Mr. Barrie Ross, surgeon, Impresario.

Dr. Drummond Rennie, a stethoscope entwined in his short irons, swung on the ladies' tee, a raffia hat of curious workmanship shading his weather-beaten face. Various drives were driven, and competition became rife.

Mr. Bob Crosthwaite, from the world centre for trauma, Houston, Texas, rolled down the narrow fairways like a professional, though not a golfing one. Dr. Hywel Davies pursued a more varied course, cursing, whilst Dr. Rennie lost three balls in three patches of gorse. At the sixth, four grown men averaged nine shots each, Mr. Mike Pagliero winning with his five.

The evening sun shone. A glorious sunset set. Behind, Mr. J. C. Gazet took a 72 (to the turn) and Mr. John Duff developed a migraine studying Mr. Gazet's swing. Mr. Barrie Ross, who was later conspicuous in a tie, and who's dress was ideally suited to the occasion (his 40th birthday) played to a handicap.

Mr. Ross Watkin was shown how to hold a golf club, and shortly afterwards actually putted into a bunker. This second group were round in four-and-a-half hours, playing the last hole entirely by ear, without any falling off in the standard of play.

Twenty-three balls lost: Mr. Pagliero, round in 84, the winner.

Later, Dr. Hywel Davies ate his second steak and kidney pie of the day (a Welsh national record). Mr. Ross produced a plank and everyone slept well, though Mr. Duff had a nightmare about Mr. Gazet.

The next morning, weighted with porridge, to Aldeburgh, blue sky, a steady breeze, dinghies on the inlet, yachts on the sea, gorse crowding the fairways.

Dr. Hywel Davies suffered the inevitable reaction and was six down after six holes. Mr. Duff played strokes of astonishing beauty—one, from deep rough, producing two balls.

His opponent played Dr. Rennie's ball out of a deep bunker, helping Dr. Rennie to a nett score, on his own handicapping, of 52 (a course record).

Mr. Bobby Gumpert arrived in mid-round and played with spectacular brilliance for an after-lunch 115, each stroke a joy for his opponent to watch.

Mr. Gazet played a trick shot of truly surgical ingenuity into the club house before he retired, hurt. Mr. Barrie Ross sparkled fitfully.

Mr. Pagliero, at the turn in 39, was 12 over fours for the next three holes with approach shots of majestic but regrettable power. Mr. Bob Crosthwaite mislaid six large American balls.

Night fell on Mr. Duff, Mr. Pagliero, and Dr. Rennie, all playing the 45th hole that day. Mr. Duff was savagely bitten by a mosquito in the twilight of the last green.

A nett profit of 6d. was made on the fruit slot machine.

Mr. Ross organised the whole meet with efficiency and flair.

The day following, Mr. Bob Crosthwaite was found to be suffering from trauma.

I.D.B.R.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Registrar in Clinical Pathology,** with duties commencing as soon as possible, and appointment until 30th September, 1966, in the first instance. Forms of application are available from, and should be returned to, the Superintendent, Guy's Hospital, London, S.E.1., not later than **25th October, 1965.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Senior Registrar in Diagnostic Radiology** (two vacancies) with duties to commence either on 1st December, 1965, or 1st January, 1966, and appointment until 30th September, 1966, in the first instance. Applicants should hold the D.M.R.D. A higher medical or surgical qualification would be an advantage. Forms of application are obtainable from, and should be lodged with the Superintendent, Guy's Hospital, London, S.E.1, not later than **23rd October, 1965.**

BEXLEY H.M.C., DARTFORD H.M.C.

Senior House Office in Psychiatry required. Single, and possibly married, accommodation available. Duties will be at the Psychiatric Unit, West Hill Hospital, Dartford, for six months, and at Bexley Hospital for six months by interchange with a similar post. The Hospitals are 17 and 14 miles respectively from London, and there are good travelling facilities.

The Psychiatric Unit has 51 In-patient beds, Day Hospital facilities and Out-patient Clinics.

Bexley Hospital has over 1,900 beds dealing with all types of psychiatric illness. The post offers experience in modern physical, occupational and psychotherapeutic procedures and community care.

Clinical Instructions, Tutorials in Psychology given and facilities exist for attending D.P.M. Courses. The post is recognised for D.P.M.

Hospitals may be visited by arrangement.

Applications, giving two references, to Group Secretary, Bexley H.M.C., Bexley Hospital, Dartford Heath, Bexley, Kent, within ten days.

THE ROYAL MARSDEN HOSPITAL, SURREY BRANCH, DOWNS ROAD, SUTTON, SURREY

Applications are invited for the post of **Resident Senior House Officer** (with surgical duties). This is a post graduate teaching hospital—a radiotherapy centre with high energy apparatus and 99 beds. Application forms can be obtained from the Administrator, to whom they should be returned as soon as possible.

GREENWICH DISTRICT HOSPITAL

Miller General Wing, Greenwich High Road, S.E.10. (189 beds). **House Physician,** vacant 1st December. Six months appointment. National salary and conditions. Write with testimonial/references to Group Secretary, G. & D.H.M.C., Greenwich District Hospital, St. Alfege's Wing, Vanbrugh Hill, S.E.10.

GREENWICH DISTRICT HOSPITAL

Miller General Wing, Greenwich High Road, S.E.10. (189 beds). Recognised for F.R.C.S. Examination. **House Surgeon,** vacant 1st December. Six months appointment. National salary and conditions. Write with testimonials/references to Group Secretary, G. & D.H.M.C., Greenwich District Hospital, St. Alfege's Wing, Vanbrugh Hill, S.E.10.

GUY'S HOSPITAL, S.E.1.

Applications are invited for the appointment of **Registrar in the Dental Casualty Department,** to attend on five sessions per week with duties commencing 1st December, 1965, or as soon thereafter as possible. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, London, S.E.1, not later than **Friday, 29th October, 1965.**

GUY'S HOSPITAL, S.E.1.

December 1st, 1965

Applications are invited for the following House Appointments at Guy's Hospital, due to begin on December 1st, 1965; applications giving choice of post and choice of Hospital, in order of preference, to be lodged with the Superintendent, not later than **October 29th, 1965.**

Assistant House Surgeons

Pre-registration 4

The appointment will be for six months, the first three to be spent as A.H.S. During the second three months of the appointment candidates will move either to the post of Casualty Officer (Surgical) or will remain as A.H.S.

These vacancies will normally be open only to pre-registration candidates applying for their first appointment and not to candidates seeking their second six months' appointment.

Assistant House Physicians

Pre-registration 5

The appointment will be for six months, the first three to be spent as A.H.P. During the second three months of the appointment candidates will move either to the post of Casualty Officer (Medical) or will remain as A.H.P.

These vacancies will normally be open only to pre-registration candidates applying for their first appointment and not to candidates seeking the r second six months' appointment.

Casualty Officers
Pre-registration 6

House Surgeon to the Surgical Unit
Pre-registration 1
(2nd six months)

House Surgeons 2
1 Pre-registration
1 Pre- or Post-registration

House Physicians 3
2 Pre-registration
1 Pre- or Post-registration

Resident Obstetrician
Post-registration 1

Gynaecological House Surgeon
Pre- or post-registration 1

Throat and Ear House Surgeon
Pre- or Post-registration 1

Orthopaedic House Surgeons
Pre-registration 2

Dermatological House Physician
Post-registration 1
(to commence 1.2.66)

Genito-Urinary House Surgeon
Pre-registration (2nd six months) or Post-registration 1

House Surgeon to the Thoracic Unit
Pre- or Post-registration 1

Children's House Physician
Pre-registration (2nd six months) or Post-registration 1

Children's House Physician at the Evelina Hospital. (Four months medicine, two months surgery, with casualty duties.)
Post-registration 1
(To commence 1.2.66)
(Recognised for the D.C.H.)

***Casualty Officer (part-time, non-resident)* at the Evelina Children's Hospital**
S.H.O. (six sessions a week, Monday to Saturday mornings)
(To commence 1.2.66, for six months)

House Physician in Clinical Pathology
S.H.O. 1

House Physician in Child Psychiatry (part-time Guy's, part-time Evelina)
Post-registration 1

R.M.O., Nuffield House
S.H.O. 1
(To commence on 1.1.66)

Resident Anaesthetists 2
1 S.H.O.
1 Post-registration

ST. OLAVE'S HOSPITAL

House Physician to Dr. Mason and Dr. Cox
Pre-registration 2
(To commence 1.1.66)

House Surgeon to Mr. O'Flynn
Pre-registration 1
(To commence 1.1.66)

House Surgeon to Mr. Lewys-Lloyd
S.H.O. 1
(To commence 1.12.65)
(Recognised for F.R.C.S.)

Gynaecological House Surgeon
S.H.O. 1
(To commence 1.2.66)
(Recognised for the F.R.C.O.G.)
Casualty Officer
S.H.O. 1
(To commence 12.1.66)
(Recognised for F.R.C.S.)

NEW CROSS HOSPITAL
House Physician in Medicine and Geriatrics
S.H.O. 1
House Physician in Medicine and Geriatrics
Pre-registration 1
Orthopaedic House Surgeon
S.H.O. 1
(To commence 1.1.66)

IT IS CONFIDENTLY ANTICIPATED THAT ST. OLAVE'S AND NEW CROSS HOSPITALS WILL BE DESIGNATED TO THE GUY'S HOSPITAL BOARD OF GOVERNORS AS FROM NOVEMBER 1st, AND WILL THEREFORE BE INTEGRATED WITH GUY'S.

The Medical Committee will also consider applications for appointments at outer hospitals as follows:—

BECKENHAM HOSPITAL
House Surgeon
Pre-registration 1

JOYCE GREEN HOSPITAL
House Physician
Pre-registration 1
(To commence 14.11.65)

LEWISHAM HOSPITAL
House Physician to Dr. Roberts
Pre-registration 1
(To commence 19.12.65)

ORPINGTON HOSPITAL
House Surgeon with Gynaecology
Pre-registration 1
House Surgeon with Orthopaedics
Pre-registration 1
House Surgeon with E.N.T.
Pre-registration 1
(To commence 15.12.65)
House Surgeon with Ophthalmology
Pre-registration 1
(To commence 20.12.65)

PEMBURY HOSPITAL
House Surgeon
Pre-registration 2
House Surgeon with Gynaecology
Pre-registration 1
(To commence 1.1.66)
House Surgeon with Orthopaedics
Pre-registration 1
(To commence 7.1.66)
House Surgeon with Orthopaedics
S.H.O. 1
(To commence as soon as possible)

QUEEN MARY'S HOSPITAL, SIDCUP
House Surgeons
Pre-registration 2
House Physician
Pre-registration 1
(To commence 1.1.66)

ST. JOHN'S HOSPITAL, LEWISHAM
House Surgeon with Gynaecology
Pre-registration 1
House Surgeon with Gynaecology and Orthopaedics
Pre-registration 1
(To commence 4.1.66)

NOTICE FOR PRE-REGISTRATION CANDIDATES

Pre-registration candidates are reminded that the number of posts at Guy's is small compared with the number of students who are likely to qualify. Students applying at Guy's, therefore, are advised to consider applying for pre-registration posts elsewhere at the same time, in order to avoid delay in obtaining a post. A number of recognised posts are available in the South-East Region. Details of posts in this region and elsewhere in the country are available in the Medical School Office.

Pre-registration candidates who have completed six months in Medical or Surgical posts are reminded that they must now apply for Surgical and Medical posts respectively. A candidate who has completed his first six months in a specialty (Surgical or Medical) may not do another six months in a specialty, but must seek a post in general medicine or general surgery as the case may be, according to G.M.C. regulations.

J. B. BLAIKLEY,
Superintendent.

October 1st, 1965.

ENTRY OF STUDENTS

October, 1965

MEDICAL SCHOOL

First M.B. Students

Name	School
Addison, Linda	Horsham High School
Bennet, P. E.	Paddington Technical School
Bowden, S. E. T.	St. Joseph's College, Stoke-on-Trent
Chase, R. G.	Oundle
Coates, P. K.	Gilbert Rennie School, Lusaka, Northern Rhodesia
Dow, Rosalind C. S.	Bury St. Edmunds County Grammar School, Suffolk
Fan Lun, H. K. C.	Royal College, Curepipe, Mauritius
Harrison, P. R.	Westminster School
Hoare, Gillian L.	St. Peter's School, Coulsdon, Surrey
Hogwood, Elizabeth	Brighton and Hove High School for Girls
Horsley, S. D.	Kendal Grammar School, Westmorland
Ironside, Alison	Nottingham High School for Girls
Lunn, P. G.	Prince of Wales School, Nairobi, Kenya
MacDiarmid, D.	Dingwall Academy, Ross-shire
Moynahan, Clare H. A.	Cheltenham Ladies' College
Punt, J. A. G.	Epsom College
Ross, A. M.	Radley College
Speight, R. G.	Alleyn's School, Dulwich
Thomas, D. V. P.	Epsom College
Walton, B. E.	Nottingham High School
Watson, Deidre C. T.	P.N.E.U. School, Sussex

Second M.B. Students

Akasheh, B. F.	De La Salle College, Amman, Jordan
Armstrong, D.	Bede Grammar School, Sunderland
Aruotore, S. G.	Christ the King College, Onisha, Nigeria
Aspin, D. G.	Arnold School, Blackpool
Bartlett, Jennifer A.	Loreto College, St. Albans
Bates, J. L.	King Henry VIII Grammar School, Coventry

Beattie, T. C. H.	Rugby
Bell, A. A.	Gordonstoun
Bellamy, D.	Cathay's High School, Cardiff
Birtwhistle, Janet M.	Harrogate College
Boll, M. D.	Canford School, Dorset
Camm, A. J.	Barton Grammar School, Lincs.
Carmichael, R. D. G.	Wellington College, Crowthorne, Berks.
Caro, A. J.	Caterham School, Surrey
Chan, K. K.	Culford School, Bury St. Edmunds
Cox, C. J. C.	St. Joseph's College, Beulah Hill, S.E.19.
Crighton, B. McK.	Canford School, Dorset
Curson, D. A.	Grangefield Grammar School, Stockton-on-Tees
Daddy, Suzanne	Parkstone Grammar School, Poole, Dorset
Davies, D. L.	Dean Close School, Cheltenham
Denyer, M. E.	Clifton College, Bristol
Dodd, N. J.	Ardingly College, Haywards Heath
Dutta, T.	St. Paul's School, Jalapahar, Darjeeling
Edbrooke, D. L.	St. Peter's School, York
Elliott, D. R.	Wyggeston Grammar School, Leicester
Evans, P. J. D.	Heversham Grammar School, Westmorland
Govan, J. A. A.	Tonbridge School
Gude, R. A.	Douai School, Woolhampton, Nr. Reading
Hartley, R. D.	Kirkham Grammar School, Lancs.
Hawkins, M. J.	Rugby
Henry, M. M.	Steyning Grammar School, Sussex
Hey, G. B.	Hutton Grammar School, Lancs.
Higenbottam, T. W.	Moseley Hall Grammar School, Cheadle, Cheshire
Hill, Alison P.	St. Paul's Girls' School, Brook Green, W.6.
Hollis, M. J.	Epsom College, Surrey
Horrocks, M.	Chesterfield Grammar School
Howard, K. M.	Brighton College
Huggett, S. F.	Harrow
Huchinson, A.	Stamford School, Lincolnshire
Jack, T. M.	King Edward's School, Edgbaston, Birmingham
Jones, D. A.	Rhondda County Grammar School
Kenning, B. R.	St. Mary's College, Twickenham
	St. Edward's College, Market Drayton, Salop
Knight, M. A.	Epsom College, Surrey
Kraemer, J. W. S.	Lancing College, Sussex
La'ajam, M. A.	Hantoub Secondary School, Sudan
Langford, D. T.	Howardian High School, Cardiff
Leask, Vivien R.	Edgbaston High School for Girls, Birmingham
Longhurst, N.	Palmer's School, Grays, Essex
McCarthy, Cornelia A.	St. Joseph's Convent, Watford, Herts.
Mandeville, R. P.	University College School, Hampstead
Morrison, Joanne M.	Godolphin School, Salisbury, Wilts.
Morton, D. N.	St. Albans County Grammar School
Nath, H.	Merchant Taylor's, Liverpool
Neville, E.	Douai School, Woolhampton, Nr. Reading
Noble, C. J.	St. Olave's and St. Saviour's Grammar School, S.E.1.
Pitt-Payne, J. H.	Epsom College, Surrey
Pook, J. A. R.	Tonbridge School
Reinhold, P. H.	*Wellington College*, Crowthorne, Berks.
Rosenberg, D. A.	Brighton College
Rosenberg, J. N.	Leyton County High School
Rutland, M. D.	Farnborough Grammar School
Savage, R. H.	Chiswick County Grammar School
Sharpe, P. C.	Woodhouse Grammar School, Finchley
Shiu, W.M.F.	Wah Yan College, Hong Kong
Smith, W. H.	Haileybury
Steer, P. J.	Langley Grammar School, Bucks.
Stephenson, Deborah J.	Cheltenham Ladies College
Sutherland, A. R.	Felsted School, Essex
Thompson, M. A.	Haileybury
Thorne, Catherine H.	Cheltenham Ladies' College
Tihanyi, Anna-Maria	Northlea School, Bulawayo, Southern Rhodesia
Toone, P. C.	Canford School
Townsend, E. R.	Badingham College, Leatherhead
Treasure, T.	St. Boniface's College, Plymouth
Trompeter, R. S.	Orange Hill County Grammar School, Edgware
Vellacott, M. N.	St. Lawrence College, Ramsgate
Voss, G. C.	Cathedral School, Hereford
Vulliamy, C. B.	Canford School
Wainwright, R. J.	George Dixon Grammar *School, Edgbaston*
Walker, Angela M.	Dorking Grammar School
Ward, D. E.	Old Swinford Hospital, Stourbridge
West, A. J.	Cheltenham College
White, A. C.	King Edward's Five Ways School, Birmingham
Williams, H. J. H.	St. Paul's School
Woodhouse, C. R. J.	Winchester College
Worby, M. E.	West Hill Grammar School, Dartford
Wynburne, Heather J. M.	Ashford Grammar School

Combined Course

Tomlins, C. D. C.	Bradfield College, and Guy's Hospital Dental School

Clinical Students

Barber, C. G.	Marlborough College & Magdalene College,
Boxley, J. D.	Christ's Hospital & Christ's College, Cambridge
Brooks, A. S. B.	Lowestoft Grammar School & Downing College, Cambridge

Calin, A.	Epsom College & Clare College, Cambridge
Cheesbrough, M. J.	Queen Elizabeth Grammar School, Wakefield & Emmanuel College, Cambridge
Hewat-Jaboor, D. F.	Fettes College & Christ's College, Cambridge
Hibbert, J.	Grammar School for Boys, Barrow-in-Furness, & Trinity College, Cambridge
Miller, J. P.	Repton School & Keble College, Oxford
Reeve, J.	Gresham's School & Oriel College, Oxford
Rogers, H. J.	Chislehurst and Sidcup Grammar School & Downing College, Cambridge
Ross, G. A. W.	King James's Grammar School, Almondbury & Gonville and Caius College, Cambridge
Schott, G. D.	Leighton Park School, Reading & Emmanuel College, Cambridge
Swift, P. G. F.	Wyggeston School, Leicester & Downing College, Cambridge
Thomas, D. G.	Gravesend Grammar School & Clare College, Cambridge
Thomson, A. A. G.	Dulwich College & Magdalene College, Cambridge
Thomson, Gillian	Cheltenham Ladies' College & Girton College, Cambridge
Watkins, D. J.	Royal Grammar School, Guildford & Sidney Sussex College, Cambridge

October, 1965

DENTAL SCHOOL

First Year B.D.S. Students

Abbey, Elaine V. G.	Beresford House School, Eastbourne
Ashley, M. F.	Bedford School
Brown, E. P.	Gravesend Technical High School
Cartwright, Margaret E.	Newland High School, Hull
Chan, D. K. F.	St. Louis Catholic English School, Hong Kong
Cowling, J. S.	Havelock School, Grimsby
Dine, J. P.	Andover Grammar School
Evans, A. M.	Ystalyfera Grammar School, Swansea
Greenway, H.	Sandown Grammar School
Hunt, P. R.	Mill Hill
Lane, R. J.	Henry Mellish Grammar School, Nottingham
Leeburn, R. V.	Bassaleg Grammar School, Mon.
Moulder, P. J. M.	Boston Grammar School
Parry, Susan	Ystalyfera Grammar School, Swansea
Powell-Cullingford, Mary D.	Guildford High School
Street, Felicity J.	Frensham Heights
Timmis, Joanne C.	Cannock Grammar School
Waterhouse, G. R.	King's School, Canterbury
Watson, Pamela J. M.	Roedean

Second Year B.D.S. Students

Adkins, M.	Bromsgrove School
Anderson, R. L.	Bedford School
Avery, B. S.	Abingdon School
Bailiff, Rosemary P.	Dover Grammar School
Baker, Jeanne E.	Stratford House School, Bickley, Kent
Bell, A. W. A.	Liskeard Secondary School
Benson, Patricia J.	Stamford High School
Blakesley, D. M.	Bishop's Stortford College
Blanks, Carol A.	Wimbledon County Grammar School
Blinkhorn, A. S.	Carre's Grammar School, Lincs.
Budden, P. G.	Christ's Hospital
Carrotte, P. V.	Clee Humberston Foundation
Carver, J. M. L.	Dynevor Secondary Grammar School Swansea
Clark, R. K. F.	Millfield
Collins, Ann P.	St. Joseph's Convent, Reading
Cragg, J. G.	Hampton Grammar School
Davidson, D. W.	Henry Mellish Grammar School, Nottingham
Davis, A. J.	Plymouth College
Douglas, W. H.	Annadale Grammar School, Belfast
Doyle, S. J.	Thornleigh Salesian College
Duck, Mary O.	Maryville Convent, Welling
Farber, G.	Hackney Downs School
Fordham, M. G.	Ratcliffe College, Leicestershire
Gillham, A. J.	St. George's College, Weybridge
Gooder, P. N.	Bradford Grammar School
Greenland, Valerie A.	Shaftesbury High School
Haigh, P. A.	Bramcote Hills Grammar School, Nottingham
Haynes, P. J. C.	Henry Smith's School, Co. Durham
Haywood, T. G.	St. Michael's College, Hitchin
Heaton, G. M. A.	King's School, Canterbury
Hughes, Victoria	Erdington Grammar School
King, J. D.	William Hulme's Grammar School, Manchester
Latimer-Sayer, E. G.	Thames Valley Grammar School
Lindridge, D.	St. Mary's College, Middlesbrough
Lovell, R. P. A.	Newcastle High School, Staffs.
Marsh, S. A.	Abingdon School
Pearson, C. R.	Bromsgrove School
Powell, O.	Friend's School, Saffron Waldon
Pullinger, A. G.	Watford Grammar School
Reece, P. A. J.	Staveley Secondary Modern School
Smith, B. J.	King Henry VII School, Coventry
Smith, C. M.	Dorking County Grammar School

Smith, Elizabeth J. E.	Wycombe Abbey, Bucks.
Stearns, M. P.	Gillingham Grammar School
Taylor, K.	Hemel Hempstead Grammar School
Thomas, D. P. S.	North-West Kent College of Technology
Tudor-Williams, R.	Haverfordwest Grammar School
Veale, P. B.	Merrywood Grammar School, Bristol
Walker, P. R.	Lincoln School
Watson, Elizabeth J.	St. Catherine's School, Bramley, Surrey
Watts, A.	Gravesend Grammar School
White, Susan J.	Devonport High School, Plymouth
Williams, P. C.	Newport High School
Winter, N. R.	Skinner's School, Tunbridge Wells

One Year's Hospital Practice

Stinton, L. C.	University of West Australia Dental School

NURSING NEWS

Entered:

Sister M. Ballamy to Caleb Ward.
Sister B. Edwards to Night Duty.
Sister J. Flower to School of Nursing.

Left:

Mr. R. Clay from Night Duty.

Birth, Marriage, Death, and Change of Address notices are without charge to subscribers. For Personal notices the charge is £1 1s. 0d. for 15 words, additional five words 10s. 6d., minimum 15 words. Non-subscribers will pay £1 1s. 0d. for all notices other than Personal which will be charged at the above rate.

PERSONAL

COSTA DEL SOL. Luxury flat on beach. Near Estepona, sleeps 4-5. Available mid-October onwards. Telephone Harrow 1184.

Locum wanted, 6-7 month period from mid-June, 1966, seaside town, Bay of Plenty, New Zealand. Most attractive terms. Suitable for intending immigrant. Rent-free fully furnished house. Contact Mr. J. Goodliffe, Appointments Officer.

Young Guy's man requires assistant in friendly practice 55 miles north of London. New equipment and plenty of work. Excellent remuneration on high percentage basis for young colleague practicing good dentistry. Box No. 35.

CHANGES OF ADDRESS

Miss A. L. Perkins, Little Orchard, 7, Castle Way, Steyning, Sussex.

Mr. and Mrs. J. C. Stephenson, 5, Hunstrete, Pensford, Nr. Bristol, North Somerset. Tel. No. Compton Dando 289.

BIRTHS

LEWIS.—On 27th September, in Nuffield House, to Bunty, wife of T. L. T. Lewis, a son.

LESSOF.—On 25th September, to Leila (née Liebster) and Maurice Lessof, of 8, John Spencer Square, N.1., a daughter (Caroline Ruth) a sister for Nicholas and Susan.

PENNY.—On 25th September, 1965, to Gillian (née Needle) and Dr. Richard Penny, a son, James Richard, a brother for Susan.

BROWN.—On October 6th, to Catherine and Austin Brown, F.R.C.S., 1, Lloyd Road, Hove, a son, Simon, brother for Wendy, Diana and David.

ENGAGEMENTS

Miss Carole Anne Richards, S.R.N., S.C.M., of Caterham, Surrey (Guy's 1955-59), to Bryan Arthur Simons, of Purley, Surrey.

MARRIAGES

We wish to announce that Mrs. Lydia Lees Read was re-married on the 21st September, 1965. Her husband is Mr. Arthur Franks, O.B.E., Chairman of the Tottenham Group Hospital Management Committee, and a Member of the North East Metropolitan Regional Hospital Board. Mr. Franks is also on the Council and the Development Committee of the King Edward's Hospital Fund for London.

We take this opportunity of wishing Mrs. Franks every happiness.

EDITORS P. BOWDEN AND A. E. RAYNES
SPORTS CORRESPONDENT A. PROCTER
FORTNIGHTLY TWO SHILLINGS VOLUME 79 NUMBER 2015

PASSIM

Waiting

On 2nd September, 1965, a small book was published for the Nuffield Provincial Hospital Trust by Oxford University Press, it's title, Waiting in Out-patient Departments. Guy's Professor W. J. H. Butterfield was a member of the advisory panel. The clinics of 60 hospitals were studied giving a total of some 12,500 out-patient visits observed. These numbers compare with the 1952 survey of 6,800 visits at 34 clinics of 9 hospitals. The overall mean waiting time deduced from the latter survey was 56 minutes and the major causes of delay were the unpunctual attendance of doctors and the over booking of clinics.

The later survey shows that waiting time has been reduced to an average 25 minutes and 11 per cent of patients had to wait more than one hour. Most arrived early and although 13 per cent of patients failed to keep their appointment, the time wasted by doctors because patients failed to present themselves or were late, was, on average, less than two minutes. Only one in five clinics started on time and they were, on average, twelve minutes late in starting. Two per cent were more than one hour late. As in the 1952 survey, clinics were found to be overbooked and the survey recommends that some estimation of consultation time should be arrived at rather than merely booking people at times irrespective of the individual requirements of the patient.

Democratic Caries

Recently, the Kent Health Committee rejected the recommendations of the Minister of Health for fluoridation of the water supply. The political system which allows a local government to over-rule a directive from the central government is one of the country's greatest heritages and permits preservation of local character by representatives of the people concerned. It is unfortunate, however, that by this system the public depends on the assessment of highly technical matters by unqualified people.

The Kent Health Committee, like those of many other local authorities, contains no medically qualified person and yet it was their responsibility to consider and pass judgment on the proposals of the minister, which are based on the results of detailed research. This work has shown that fluoridation is a signficant preventive measure and that it is also completely safe. Research directed at improving the general health of a population would seem to be of little value if it depends on a medically uneducated committee for its evaluation and institution.

The Health Committee could hardly criticize this particular measure on its preventive value for this seems to be established, but the ethics of this form of prevention met with their disapproval. The Minister of Health, in proposing this as a general measure also implied that its ethics are acceptable.

Freedom of the individual must always be valued and the Kent Committee is right in being concerned about this. However, they are interpreting these rights as the freedom of the individual to become ill. It is to prevent this that they already purify the water supply and by their own reasoning this, too, is unethical.

Chronic

One of the several deficiencies of the present National Health Service is the unfortunate shortage of homes for the incurable.

All who have worked on the medical wards are well aware of those patients who are beyond all but palliative therapeutic assistance and who have become chronic nursing problems. Usually they are geriatic cases or have diseases such as Parkinsonism or multiple sclerosis: in most instances they are too much for the relatives to manage although quite often, there are no relatives to be found. Admitted to be tided over an acute episode they end up occupying beds in general hospital wards for an indefinite period of time, until the houseman or almoner can perform the conjuring trick that is necessary to get them into a proper unit catering for long-term patients and not, one hopes, harbouring the usual hospital flora.

The Cheshire Homes and the like have at the moment waiting lists of from six months to many years, and the problem of staffing these places is extremely difficult. One wonders, in fact, how many of our young Guy's nurses would choose to look after only really hopeless cases—and for how long.

Perhaps in the future planning for such patients, it would be best if, as has been suggested, the larger hospitals at any rate, each had their own homes for the chronically sick, staffed by their own nurses in the usual rotation. In this way the burden of looking after these invalids would be justly shared and more beds would be freed in the General Hospitals for those in need of more immediate assistance.

Mission to Vietnam

On behalf of the Ministry of Overseas Development, Dr. P. R. Evans is at present in Saigon to review the children's hospitals. He will report to the British Government on conditions and any need for assistance.

Birmingham Appointments

Dr. J. G. P. Hutchinson has been appointed Director of the Public Health Laboratory at Birmingham.

Dr. R. H. R. White has been appointed Senior Lecturer in Paediatrics and Child Health to the United Birmingham Hospitals.

At the end of September, 1965, Mr. R. E. Rix retired from the position of Dental Surgeon to the Children's Department, to which he was appointed in 1946. He qualified L.D.S., R.C.S. in 1925, and three years later L.R.C.S., M.R.C.P. In 1948 he achieved the distinction of F.D.S., R.C.S. We wish him a long and happy retirement. A further appreciation will appear in the next gazette.

Guy's men will be pleased to learn that Surgeon Captain (D) B. W. Pett, V.R.D., R.N.R., has been appointed honorary Dental Surgeon to her Majesty the Queen. This appointment was recently announced by the Minister of Defence and takes effect from the 1st October, 1965. This is the second occasion on which such an appointment has been made to a Reserve Dental Officer, the previous recipient being Surgeon Captain John Symmons, also a Guy's man.

It is with deep regret that we report the death, on October 4th, of Francis Ryder, L.D.S., R.C.S., Eng., at the age of ninety-two. He qualified at Guys in 1904. He leaves two brothers and a sister, to whom we offer our sincere condolences.

It has been reported in the "South African Medical Journal" that Dr. Jacobs Francois le Clus, who qualified from Guy's in 1950, died suddenly at his home in Kempton Park, South Africa, on 19th June, 1965. He leaves a widow, two sons and two daughters, to whom we offer our deepest sympathy.

GUY'S DIARY

OCTOBER			
EXHIBITION			Bone Tumours.
NOVEMBER			
1st	M.	1.00	Clinical Lecture. MR. GIBBERD. *"Maternal Mortality in the 1960's"*
1st	M.	4.30	Applied Physiology Lecture. Physiology Theatre. PROF. W. J. H. BUTTERFIELD. *"Clinical Physiology of Diabetes Mellitus"*.
1st	M.	5.30	Psychological Society. *"What is psychology"* Speaker DR. STAFFORD-CLARK. Anatomy Theatre.
2nd	T.	1.00	Clinical Lecture. MR. ECKHOFF. *"Flaps and Tubes"*
4th	Th.	1.00	Clinical Lecture. MR. JACK DAVIS M.D. Hand Surgeon to the British Hospital, Buenos Aires. *"Dupuytren's Disease"*
4th	Th.	4.30	MR. W. R. B. JOHN and MR. D. S. BRIGGS, Speakers. Subject *"Applications of Muscular Physiology"*. Chairman DR. D. H. DAVIES.
5th	F.	1.00	Clinical Lecture. DR. MacLEAN.
8th	M.	1.00	Clinical Lecture. MR. KINDER. *"Tumours of the Bladder"*
11th	Th.	4.30	MR. M. C. EDE ; Speaker. Subject *"Glycosuria and Diabetes in a North American Indian Population"*. Chairman DR. H. KEEN.
12th	F.	1.00	Clinical Lecture. DR. HOUSTON.

THE PATHOLOGY OF PERINATAL ANOXIA

by

Roy G. Spector

Paediatric Research Unit, Guy's Hospital Medical School, London, S.E.1

The perinatal period extends from the end of 28th week of gestation to the end of 1st week after delivery. Oxygen lack during this time is an important cause of stillbirth, death in the first week and permanent brain damage in survivors.

CAUSES OF PERINATAL ANOXIA

(i) **Factors operating during pregnancy.** Pre-eclamptic toxaemia, placental dysfunction occurring in pregnancies which have progressed beyond 40 weeks, retroplacental haemorrhage and other types of premature placental separation are the commonest recognisable causes of foetal anoxia before the onset of labour. Other causes include massive placental infarction, extensive thrombosis of placental vessels, maternal diabetes and maternal anoxia.

(ii) **Factors operating during labour.** Prolonged labour and cord complications (such as prolapse or torsion) can cause severe foetal anoxia. Perhaps equally important is the additive effect of chronic anoxia during pregnancy with the physiological stress of labour—for example, a common time of death in fatal instances of pregnancy which has progressed an unusually long period of time beyond 40 weeks is during the 1st and 2nd stages of labour.

(iii) **Factors operating after delivery.** The chief of these are prolonged apnoea after delivery and lung disorders in the first week of life. A long period of apnoea at birth may be a result of intrapartum anoxia and/or cerebral birth trauma. The diseases of the lungs which occur in the first week include failure of expansion, pulmonary hyaline membrane, intrapulmonary haemorrhage and pneumonia.

Kernicterus may be considered as a form of "histotoxic" anoxia. It is the type of brain damage produced by abnormally high blood levels of non-conjugated bilirubin. This form of bilirubin is neurotoxic.

CONDITIONS ASSOCIATED WITH PERINATAL ANOXIA

(i) **Stillbirth.** The National Birthday Trust Perinatal Mortality Survey (Butler and Bonham, 1963) investigated 1,407 stillbirths born in Great Britain during March, 1958. The stillbirth rate was found to be 19.8 per 1,000 total deliveries. Of these intrauterine deaths, 30.8% (6.1/1,000 total deliveries) were caused by intrapartum anoxia, and this was found to be the commonest cause of stillbirth. 17.4% of deaths were due to antepartum anoxia and 7.8% showed evidence of both intrapartum anoxia and cerebral birth trauma.

(ii) **Death in the first week of life.** Butler and Bonham found the first week death rate to be 11.3 per 1,000 total deliveries. In the group of first week deaths as a whole, congenital malformation was the commonest cause of death (21.6%). Next came pulmonary hyaline membrane (15%), pneumonia (13.3%), no lesion apart from failure of alveolar aeration (8.7%), intraventricular haemorrhage (6.4%), massive pulmonary haemorrhage (5.9%) and combined intrapartum anoxia and cerebral birth trauma (5.3%). The remainder of diseases in this group included cerebral birth injury, rhesus isoimmunisation and extrapulmonary infection. In children who weighed 2,500 g. or under, hyaline membrane was the commonest cause of death. 22.2% of premature children who died in the first week had this lung condition.

(iii) **Neurological damage in survivors.** Cerebral palsy has been defined as a qualitative motor disorder of cerebral origin, arising from causes operating on an immature nervous system before its growth and development are complete. Although the clinical picture is susceptible to evolution with time, the disease is essentially non-progressive. It occurs in 1 to 2 per 1,000 school children and 2 to 3 per 1,000 live births. The disorder is often associated with mental deficiency, epilepsy and sensory abnormalities. There is evidence that perinatal anoxia may be the cause of a proportion of cases of cerebral palsy, mental deficiency and epilepsy—occurring either together or as isolated clinical abnormalities. In several retrospective surveys of singletons with cerebral palsy, there was an increased incidence of malpresentations, premature placental separation, cord complications, toxaemia and bleeding during pregnancy and labour. But in two-thirds of cases no complications were present. Acute anoxia in the mother during pregnancy (e.g. coal gas poisoning; circulatory arrest) is a rare but well-substantiated cause of cerebral injury in the offspring. In asymetrical and athetotic forms of cerebral palsy, respiratory difficulties at delivery are relatively common. The longer resuscitation is required after birth, the higher the incidence of permanent brain damage.

Prematurity appears to account for 30% of cases of cerebral palsy. Alison McDonald (1962) investigated over a thousand children whose birth-weight was not more than 4 lbs. (1,810 g.). 22% had a neurological or ophthalmic disorder. 6.5% had cerebral palsy and four-fifths of these had spastic diplegia (a more or less symmetrical form of spastic paresis involving the legs more than the arms). The most constantly occurring event in premature infants who eventually developed signs of chronic brain damage was the occurrence of cyanotic attacks in the first week of life. It is therefore possible that the most important immediate danger of prematurity is the development of lung disorders and it is these which lead to anoxia and consequent brain injury.

Congenital hemiplegia and dyskinesia are the forms of cerebral palsy more commonly due to asphyxia at birth, whilst developmental malformation is a more important cause of bilateral hemiplegia and ataxic cerebral palsy.

ANATOMICAL LESIONS ASSOCIATED WITH PERINATAL ANOXIA

(A) ACUTE CHANGES

(i) **General.** Infants who have died from anoxia in utero or following delivery may show any of the following: subarachnoid haemorrhage, congestion and microscopic haemorrhages in the cortex and white matter of the cerebrum, cortical haemorrhages in the thymus, subpleural haemorrhages, subepicardial petechial haemorrhages, subcapsular haematomas of the liver, adrenal haemorrhages, renal petechial haemorrhages and flame shaped hemorrhages in the mesentery of the small intestine. Asphyxia before delivery may result in aspiration and swallowing of large amounts of liquor amnii and meconium.

(ii) **Pulmonary hyaline membrane.** This condition is only found in liveborn infants—the great majority of whom weigh 2,500 g. or less. Most fatalities occur in the first 48 hours after delivery and macroscopically the lungs are congested, bulky, purple and solid to the touch. On histological examination, an eosinophilic structureless or finely granular membrane is found to line many of the alveoli and alveolar ducts and there is much alveolar collapse with overdistention of the alveolar ducts. Intrapulmonary haemorrhages are a frequent associated feature. The cause of this condition is not known. The membrane itself consists of fibrin and arises from fibrinogen which is present in a transudate from the infant's plasma. Although it has been suggested that the excessive pulmonary transudation is a circulatory response to anoxia, it is likely that other factors, such as deficiencies of fibrinolysin and alveolar surface acting agents, may be of crucial importance.

(iii) **Intraventricular haemorrhage** is diagnosed at necropsy when blood clot is present in one or both lateral ventricles in a liveborn child. The immediate cause of the haemorrhage is rupture of small subependymal haemorrhages into the lateral ventricle. The subependymal lesions are believed to arise as a result of intrapartum asphyxia. Over 95% of children who die in the first week from intraventricular haemorrhage weigh 2,500 g. or less and 40% weigh 1,000 g. or less. 90% of deaths from this condition occur in the first 48 hours of life. The incidence of the disease is 0.7/1,000 deliveries, but is raised following severe toxaemia (1.5/1,000), essential hypertension (1.7/1,000) and vaginal haemorrhage (3.0/1,000) during pregnancy.

(iv) **Massive pulmonary haemorrhage** is diagnosed when there is extensive intraalveolar haemorrhage with no signs of pneumonia. The disease most often leads to death on the third and fourth days of life. There is a strikingly high incidence of prematurity (63% of cases) but less than 5% weighed less than 1,000 g. The National Birthday Trust Survey showed the overall mortality for massive pulmonary haemorrhage to be 0.6/1,000 deliveries. Following a pregnancy complicated by severe toxaemia, the rate rose to 3.5/1,000. The rate was 3.0/1,000 with placenta praevia. There was a marked rise in the incidence of fatal pulmonary haemorrhage following a breech delivery.

(v) **Haemoperitoneum** is a complication of approximately half of cases of subcapsular haematomas of the liver. It is most frequently associated with other evidence of intrapartum anoxia. The haemorrhage is occasionally large enough per se to endanger life.

More rarely an extensive anterior mediastinal haemorrhage may arise from rupture of a cortical thymic haemorrhage in a similar way.

(vi) **Periventricular leukomalacia** is the term used by Banker and Larroche (1962) for a disease affecting the cerebral white matter of liveborn premature infants, most of whom have suffered from severe asphyxia after delivery. These workers found that approximately 19% of 117 premature infants who died under the age of one month suffered from this disease. Macroscopically the lesions were only found in formalin fixed brain and had the appearance of white spots, streaks and small areas of softening. These occurred in the white matter adjacent to the lateral ventricles. The microscopical changes were of coagulation necrosis, microglial proliferation and gliosis. McDonald (1964) has commented on the similar association with prematurity of spastic diplegia and periventricular leukomalacia and has suggested that some cases of diplegia in premature children could arise from this type of white matter lesion because of destruction of part of the cortico-spinal motor tracts. The reason for this peculiar vulnerability of the white matter in premature children is not known.

(vii) **Kernicterus.** With increase in the serum level of unconjugated bilirubin above 20 mg/100 ml. in the newborn period, there is an increasing risk of developing kernicteric encephalopathy. If the child dies in the early stages of the disease, the following structures are most commonly picked out by yellow or orange pigmentation: subthalamic nucleus, pyramidal layer of the hippocampus, globus pallidus, dentate nucleus, inferior olivary nucleus, the cranial nerve nuclei in the floor of the fourth ventricle, the cerebellar vermis and flocculus. The putamen, thalamus, cerebral cortex and spinal cord are less often affected. The earliest microscopical change is the deposition of pigment in the nerve cells and glia with little or no cell degeneration. After a few days much nerve cell damage occurs in the subthalamic nucleus, hippocampus and globus pallidus. The dead nerve cells are shrunken, pigmented and have dense triangular or crenated nuclei. The capillaries in these regions appear prominent and there is some proliferation of astrocytes.

(B) CHRONIC CHANGES

(i) **General effect on the brain of anoxia.** The brain is one of the most sensitive organs to oxygen deprivation. However, not all parts of the brain are equally affected—the most vulnerable regions are:—the pyramidal layer of the hippocampus (especially Rose's area h_1—also called Sommer sector), the visual and motor cortex (especially the neurones of the second and third layers), the Purkinje cells of the cerebellum and the neurones of the globus pallidus. Also, the white matter, brain stem nuclei, striatum, reticular zone of the substantia nigra, the dorsomedial and lateral nuclei of the thalamus and the ventrolateral part of the amygdaloid are frequently involved. The most vulnerable cellular element is the neurone. Within areas of neuronal destruction there is an increase in number and size of the glial cells.

(ii) **Late effects of acute lesions.** The relationships between such acute lesions are subarachnoid haemorrhage, intracerebral haemorrhage, intraventricular haemorrhage and periventricular leukomalacia to chronic brain damage is not understood. Children who survive the acute stage of kernicteric encephalopathy and who later develop choreo-athetosis and deafness show nerve cell loss and very intense fibrillary gliosis in the globus pallidus, subthalamic nucleus, hippocampus and cochlear nuclei.

(iii) **Cerebral cortex: Ulegyria (atrophic sclerosis, mantle sclerotic microgyria).** This lesion is commonly seen in any of the varieties of spastic cerebral palsy. The general convolutional pattern of the cerebral cortex is maintained but individual gyri or groups of gyri are shrunken and sclerotic. This is due to loss of nerve cells and replacement by glial tissue. Ulegyria may be present in boundary zones between main arterial territories or may fall in the region of supply of one of the cerebral arteries. The lesions may be symmetrical or affect one hemisphere. Quite often only one or two small areas of the cortex are involved.

(iv) **Centrum Semiovale.** A characteristic pathological feature of anoxia at about the time of birth is bilateral rarefaction or cavitation of the tissues adjoining the lateral angle of the lateral ventricle. This, like ulegyria, is often seen in patients suffering from spastic forms of cerebral palsy. The anatomical change ranges from mild loss of myelin with gliosis and infiltration by lipid-laden macrophages to actual cavitation which sometimes forms a communication with the lateral ventricle. A more severe lesion is extensive widespread cavitation of white matter known as "cystic degeneration". In this the greater part of the central white matter may be replaced by a series of trabeculated cavities and the overlying cortex atrophied. Many of the cases of cerebral palsy in which, at necropsy, no macroscopic lesion is found in the brain, are subsequently discovered to have widespread fibrillary gliosis of the white matter.

(v) **Basal Ganglia.** Some survivors of intraventricular haemorrhage in the newborn period may subsequently develop atrophy of the caudate nucleus or subependymal cavitation and gliosis.

Status marmoratus. This lesion is often associated with athetoid cerebral palsy and is thought to be usually the result of perinatal anoxia. It may be said to be present when myelinated nerve fibres are found in aggregations considerably in excess of what is normal for that particular region of the nervous system. The typical condition is found within and in the region of the corpus striatum. It is most commonly seen in the neostriatum and medial nucleus of the thalamus and is associated with loss of nerve cells and fibrillary gliosis.

(vi) **Thalamus.** Extensive atrophy of the thalamus is always found when widespread cortical and subcortical damage is present. This form of thalamic birth injury is the result of retrograde degeneration.

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The Aetiology of Hodgkin's Disease

by IAN A. BAKER

This paper won the Louise Buchanan Memorial Prize for 1965. *The prize was set up by the father, son, son-in-law, father-in-law and husband of Louise who died of Hodgkin's Disease at the age of* 26 *in* 1961. *The prize is* £50, *the trustees are the Dean and Professor Butterfield, and it is organised by the Department of Medicine.*

In searching for the cause of a disease, one is concerned with a wide range of possible aetiological factors, the acceptance or elimination of which, by experimental processes, leads one to differentiate between their contributory and initiating roles. This requires, therefore, a clinical and pathological definition of the disease, for which one causal agent has the exclusive initiating function. But, as Payling Wright observed, " aetiological factors in disease . . . . necessarily embrace a wide diversity of antecedent circumstances, whose reduction to coherent order gives rise to problems of great complexity." This statement finds much support in the aetiology of Hodgkin's Disease, the nature of which is still the subject of much controversy.

The disease entity, first described by Thomas Hodgkin, of Guy's Hospital in 1832, from seven cases showing common lymph node enlargement and splenic enlargement, cachexia and fatal termination, was assigned the name Hodgkin's Disease by Samuel Wilks in 1865, when he described another fifteen cases. At the present time the disease involves the following major clinical features: enlargement of one or more lymph nodes or groups of lymph nodes; splenic enlargement; sweats and a recurrent (Pel-Ebstein) fever; weight loss; an anaemia and a disturbance of the white blood cell picture; a raised erythrocyte sedimentation rate; a progressively fatal course, but involving periods of remission.

Pathologically, it is now agreed that Hodgkin's Disease appears in three ways. Typically, the disease involves groups of lymph nodes, which are of a hard, rubbery consistency, are discreet and have a white, uniform appearance on section. The histological picture shows a proliferation of reticulum cells, atypical cells, lymphocytes, granular leucoctytes fibroblasts and varying degrees of fibrous tissue. This type of Hodgkin's Disease is termed the "ordinary" type by Symmers and the "granuloma" by Jackson and Parker. Symmers describes the atypical reticulum cells in four groups; cells of unusually large size; cells with mirror-image nuclei; cells which are multinucleate; cells which are megakaryocytoid, i.e., with multi-lobed hyperchromatic nuclei and deep staining cytoplasm of irregular outline. The so-called Sternberg-Reed cells probably fall into the second or third group. This worker goes on to describe the common presence of eosinophils,

although he does not consider these essential in the histiopathology of the disease. The nodes show new reticulum fibres and extensive collagenous fibrosis. Fibrosis, and subsequent necrosis, increase with age. Splenic involvement varies, and shows islands of white, fibrous Hodgkin's tissue amongst the vascular pulp. The liver may be similarly involved. Symmers described the disease in the bone marrow intervening between the intact bony trabeculae.

The disease sometimes presents in a localized group of nodes and has a more slowly progressive course. The histological picture is of isolated reticulum cells in a lymphocytic matrix, with little fibrosis. The lymphocytes are mature and the reticulum cells are occasionally binucleate. Bizarre giant cells are absent according to Symmers in this form of the disease. Eosinophils are scanty or absent. Fibrosis consists of collagenous intersections. Symmers has termed this group the "indolent" type of Hodgkin's Disease. Jackson and Parker agree with the clinical and pathological picture, but persuaded of an infectious origin called the group, paragranulomas. From adequate biopsies and post-mortem studies, it is accepted that this more benign type does progress into the ordinary type of Hodgkin's Disease, and can even become directly a Hodgkin's sarcoma.

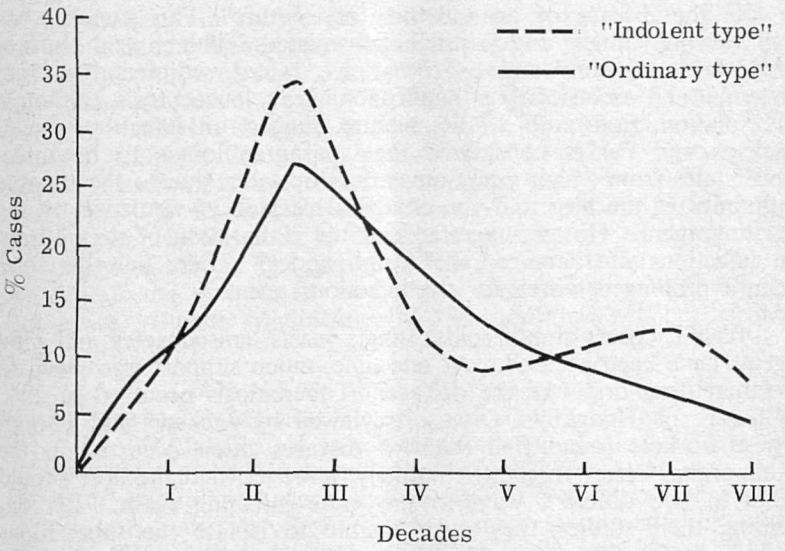
Hodgkin's sarcoma occurs in a few cases. The tissue here is anaplastic and composed mainly of large round cells with faintly staining cytoplasm and moderately chromatic vesicular nuclei. The nuclei are usually multiple or multi-lobed. The tissue is markedly invasive and the clinical course is short.

The disease as a whole is progressive and fatal. It involves varying degrees of spread, so that the lymph nodes become less discrete. Other organs become involved, either by invasion or metastasis. Jackson and Parker describe the involvement of the lungs in 40% of patients. The tissue spreads from the mediastinal and tracheo-bronchial nodes and is also found as circumscribed nodules throughout the parenchyma. The gastro-intestinal tract can be involved, probably by invasion from adjacent nodes. The kidneys in 13% of Jackson and Parker's cases showed small circumscribed nodules in the cortex. Hodgkin's tissue has also been found in the pancreas, adrenals, thyroid and thymus, again probably by extension of lymph node sources. Jackson and Parker found the central nervous system involved in 16% of cases with Hodgkin's sarcoma.

Some of the earliest thoughts on the aetiology of the disease came from Hodgkin himself. In considering his original seven cases, he stated, " as far as could be ascertained from observation, or from what could be collected from the history of the cases, this enlargement of the glands appeared to be a primitive affection of these bodies, rather than the result of an irritation propagated to them from some ulcerated surface or other inflamed texture through the medium of their inferent vessels." With regard to the spleen, he suggested, " a posterior effect and on this account may not always have been produced, when that of the glands or some other disease carried off the patient." Wilks agreed with the " neoplastic nature "

of the disease. In the late nineteenth century, however, supporters of an infectious origin of the disease arose. Greenfield in 1878, after an early microscopic study, concluded that the pathology was of a "chronic inflammation involving especially the fibrous stroma of the glands which became thickened and gradually obliterated entirely the interstices so that the gland became dense, tough, fibrous tissue with little or no adenoid structure." Sternberg, initially, in 1898 also complied with this source. He went on to postulate that the disease was "a peculiar form of tuberculosis masquerading as a pseudoleukaemia. Dorothy Reed, too, supported an inflammatory nature. Ideas developed mainly from morphological studies, but Fischer dismissed the tuberculous theory, after failing to isolate the tubercle bacilli in affected patients or inoculated animals. The confusion regarding the nature of the disease at this time was reflected in the varied nomenclature, which included lymphadenoma, malignant lymphoma, malignant granuloma, lymphogranuloma, lymphogranulomatosis.

Hodgkin's Disease, which at the present time is an accepted title, appears to have been reported in most races and sub-groups of the world's population. Symmers, in studying a large number of cases, concludes that the disease can occur at any age, but has peak incidences as illustrated by the following graph:—



Hodgkin's sarcoma is most common in the sixty-seventy year olds (Jackson and Parker). MacMahon, in an epidemiological study, divided his cases into two groups, one of 10.39 years, which had a 1:1 sex ratio, and the other of 40+ years which had a male predominance in the ratio 2:1. He suggested that the first group was associated with an infectious disease, and the second with a neoplastic-sarcomatous entity. This division seems isolated from other

factors, and the progressive nature of the disease, Razis compared the early onset of Hodgkin's Disease with carcinomata of the testes, kidneys, adrenals and bones. The sex ratio was found by Symmers to be 2:1 in favour of males at all ages. Hoster supported these findings and remarked on the similarity to the male bias in all lymphomas and leukaemias. No endocrine or occupational factors have been isolated to support the greater male incidence.

Familial studies have sometimes been subject to inaccurate definition of the disease process under review. Jackson and Parker investigating a small number of cases noted the association of other lymphomas and leukaemias in immediate relatives. Razis reported that the disease was extremely rare in twins and discovered only two concordant and five discordant cases. The same worker found that familial cases formed a small percentage of the whole picture. In studying 1,102 cases of Hodgkin's Disease and four control groups, he concluded that little more than 1% of patients with the disease have immediate relatives with the disease. This number was little more than the chance incidence, and was similar to the familial incidence of carcinomata of breast, uterus, stomach and oesophagus. None of the familial studies so far suggest any genetic or familial origin of, or predisposition to, Hodgkin's Disease.

Is the disease of an inflammatory nature? This concept has had varying support and is still not dismissed. The clinical features of fever, remissions and exacerbations, raised sedimentation rate anaemia and occasional polymorphonuclear leucocytosis, although in isolation from the whole picture, suggest an infectious agent. Jackson and Parker considered their paragranulomas to be infectious states from which granulomas develop later, due to the relative immunity of the host and the comparative lack of virulence by the exciting agent. Hoster suggested that the elaboration of toxins from an infectious site damaged the lymph nodes. There has therefore, been a prolonged search for the infectious agent.

Bacilli, cocci, diphtheroids, fungi, yeasts, spirochaetes and viral agents have been accused. At one time, much support was given to a tuberculous origin of the disease. Tuberculosis occurred in 20% of cases of Hodgkin's Disease reviewed by Jackson and Parker. These workers found that the two diseases often occurred in the same organ. They thought it unlikely, however, that the host should react in two different ways to the same infecting agent. In continuing their studies, they were unable to isolate the tuberculous bacilli from three-year-old cultures of Hodgkin's lymph node material. Further, in reviewing cases of tuberculosis at autopsy at Boston City Hospital, only 0.3% showed evidence of Hodgkin's Disease. This figure was not significantly higher than the general incidence of Hodgkin's Disease, which Symmers found to be 0.23%. The latter worker reported the association of tuberculosis lesions in nodes of patients with Hodgkin's Disease at autopsy. But these same patients had shown no evidence of the former process in early node biopsies. Other schools have remarked on the falling incidence of

tuberculosis without a corresponding decline of Hodgkin's Disease. It is now generally agreed that tuberculosis is a secondary disease.

This secondary association of tuberculosis and other infections, like torulosis and brucellosis, with Hodgkin's Disease, and the absence of a response to tuberculin skin test in patients with Hodgkin's Disease, promoted immunological interest. Schier was one of several workers to take up this problem. Using the following for allergens, he recorded the diminished response of patients with Hodgkin's Disease to delayed-type skin reactions:—

ALLERGEN	RESPONSE IN: 79 CONTROLS:	43 CASES OF HODGKIN'S DISEASE
Pure Tuberculoprotein	71%	23%
Mumps Antigen	90%	14%
Candida Albicans	92%	19%
Trichophyton Gypseum	66%	16%

Schier found that the rise in circulating antibodies in Hodgkin's Disease patients after immunization with mumps vaccine was similar to that in the controls. Similar results were found by other workers using blood group substances and tetanus toxoid. The defect in immunity seemed therefore concerned with fixed antibodies and delayed-type skin reactions. Lamb found a similar defect to delayed-type skin response in 53% of Hodgkin's Disease cases. As it was possible that these subjects may not have been exposed to the allergen, naturally, thirty-two patients with Hodgkin's Disease were sensitized with dinitrochlorobenzene, which results in almost uniform sensitization in normal persons. Twenty-five of these patients were found to be anergic, even involving cases with only local manifestations of the disease. The degree of anergy was seen to vary with the severity of the disease, in some cases decreasing with prolonged remissions. Further significance of these findings will be discussed later.

As yet no bacterial or other non-viral agent has been found which supports an aetiological role in Hodgkin's Disease. Cunningham and McAlpin, after inoculating primates and monkeys, with lymph node material from patients with Hodgkin's Disease, were unable to isolate any agent. Jackson and Parker discovered a gram-positive anaerobe in their tissue cultures, but isolated the same organism from cultures of other tumours. The coincidence of other infectious diseases with Hodgkin's Disease and the natural occurrence of infectious agents in damaged lymph nodes has so far led workers on a negative search for aetiological factors.

Viruses have also been considered as causal agents in this disease, and attention to this field has been greater since the discovery of the association of viruses with some neoplasms in animals, e.g. Rous' chicken sarcoma, Shope's viral papillomas in rabbits,

Gross' parotid gland tumours in mice, and others. As yet there is little evidence that viruses cause neoplasia in man, except possibly in some cases of malignant lymphomas in African children.

One of the first attempts to investigate a viral cause was carried out by Gordon and others. He found that he could produce an encephalitis, with muscular rigidity, spasm, paralysis, wasting and death in rabbits, by inoculating them intracerebrally with emulsions of lymph nodes affected by Hodgkin's Disease. The same results were also obtained by injecting emulsions of normal bone marrow, spleen, leucocytes or pus from humans, and Turner, Jackson and Parker found a correlation between encephalogenic activity and the eosinophil count of inoculum. Another worker, Grand, cultured lymph node material from thirty-five different patients with Hodgkin's Disease, using a culture medium of fowl plasma, human serum and chick embryo extract. After forty-eight to seventy-two hours' growth, he found large multi-nucleated giant cells at the periphery of the cell mass. These cells were not seen in cultures of normal nodes or other lymphomas. The oval nuclei surrounded a large, greyish portion, which was granular and central. This area took up brilliant cresyl blue dye. These inclusion bodies were not present in cells from normal nodes. Further, he found that the supernatant fluid from these cultures and fragments of normal nodes grown for six days gave inclusion bodies in the lymphocytes or macrophages. No multinucleate cells were seen. Although these results suggested the presence of inclusion bodies associated with a virus in tissue in nodes of Hodgkin's Disease, Hoster found that similar inclusion bodies could be demonstrated in normal cells cultured on chicken embryo extract. The virus appeared to be that responsible for chicken lymphomatosis. Hoster grew normal cells in cell free extract from Hodgkin's Disease node cultures and could demonstrate no inclusion bodies. Lundbeck similarly could find no inclusion bodies in his cultures of cells of nodes of Hodgkin's Disease. Electron-microscopic studies on cultured cells from nodes with this disease and other lymphomas and leukaemias by Sykes revealed changes in the perinuclear zone and cytoplasmic inclusion bodies in 50% of cells. These changes were not seen in non-leukaemic cultures. Virus particles were not seen and the changes could not be serially transmitted to human embryo cells. There have been other reports of nuclear lesions in cultured cells consistent with virus lesions.

If viruses are present in cells from nodes of Hodgkin's Disease, and this is not yet established, it may be that tumour cells carry many different viruses, as suggested in other lymphomas and leukaemias in animals. Any virus isolated also has to support evidence that it is responsible for the changes seen in the cells or nodes. This involves serial transmission and complement-fixing antibodies, and this stage has not yet been reached in the search for virus causes of Hodgkin's Disease.

Metabolic factors have been considered as aetiological. Although a sex difference exists in the incidence of the disease, no hormonal factor has been elucidated of an aetiological role. There

is, as yet, no other evidence for a specific metabolic disturbance. Twort, after six years' work into the cause of this condition, in many of the above fields, came to the following conclusion as long ago as 1930. "An assortment of the in vivo and in vitro experiments gave absolutely barren results, in fact, so invariably did the different experimental procedures we adopted, lead to nothing that one might have been dealing with a true new growth instead of what is generally accepted as a granuloma."

Many of the clinico-pathological features of Hodgkin's Disease suggest that it is a neoplasm. For instance, its tissue specificity, pleomorphism, giant cells and abnormally-shaped cells, frequent and atypical mitoses, its evasive character and cellular metastases support this title. The natural history of the disease in all its forms is progression with wasting, to death. Some recent chromosomal studies support its neoplastic nature. Spriggs in cells from one node from one case of Hodgkin's Disease found two types of cells with mitotic figures. One group of cells were in the diploid range. The other group, which he took to be the Sternberg-Reed cells, showed hypotetraploid metaphases. The chromosome counts ranged between 79-90 with the majority at 83. Galan et al. studied ten Sternberg-Reed cells and found six cells with 83 chromosomes; the extra chromosomes varied in type from cell to cell. These workers suggest that these abnormal karotypes are similar to those seen in spontaneously occurring tumours. Ricci, however, studies 70 mitoses, mainly in the metaphase, 61 were diploid. Of the nine tetraploid, five karotypes were of exactly 92 chromosomes, the tetraploid number. An abnormal chromosome in the 17-18 group was seen in seven out of twenty-five euploid mitoses. As yet, the above studies relate to too small numbers of individuals and karyotypes to be of full significance.

The thymus was considered by Thomson to be the primary tumour, and spread was by dissemination. Jackson and Parker found no cases of involvement of the thymus in their patients and Symmers only in five. Marshall and Wood found the thymus involved in 22 out of 86 cases of Hodgkin's Disease, where the disease was of two years, two months' average duration. The thymus was a confluent mass in fifteen cases; in four cases the thymus contained tumour nodules; in two cases there was a discreet tumour; and in one case there was minimal involvement. Thirty-nine of the remaining 64 cases without involvement had had deep X-ray therapy. After careful microscopic study, these workers concluded that the organ was involved by extension of the disease from mediastinal nodes, or from the involvement of small nodes which are sometimes present on the surface of the thymus.

As many people now accept Hodgkin's Disease as a neoplasm, its cause falls into the speculative field of the origin of the malignant cell. The change in the reticulum cell may be the result of somatic mutation. Otherwise, the alteration in cell behaviour may come about as the result of some immunological change involving the intracellular proteins. In this latter case, some evidence has been put forward in relation to Hodgkin's Disease.

A variety of diseases, termed homologous diseases, have been produced by the inoculation of homologous lymphoid cells into experimental animals, when these animals have some degree of immunological tolerance. The latter state exists in newborn mice, irradiated mice and thymectomized mice. These diseases are characterised by a lymphadenopathy, splenomegaly, leucocytosis, wasting and death. The lymph nodes show a depletion of lymphocytes. The hypothesis has been put forward by Kaplan and Smithers, and others that homologous disease in mice and Hodgkin's Disease in man are similar conditions on account of the above features. They suggested that in lymphoid neoplasms in man, lymphocytes become immunologically differentiated from normal cells by antigenic deletion, but that these cells retain the ability to produce antibodies. These antibodies react with the antigens of normal lymphocytes. This process then leads to lymphocytic depletion. The lack of lymphocytes results in immunological impairment as seen previously in the study of delayed skin reactions to allergens.

The similarity of homologous disease in mice and Hodgkin's Disease in man is not complete. No fever has been observed in homologous disease. Absent as well are atypical cells of the multinucleated or Sternberg-Reed variety. In wasting disease, the form of homologous disease which occurs in thymectomised mice, there is depression of circulating antibody formation, which is unlike Hodgkin's Disease. It may be that the thymus serves some other humoral role, associated with lymphoid or immunological competence. Even so the role of the thymus may require re-examination in the cause of Hodgkin's Disease.

The association of homologous disease and the neoplastic form of Hodgkin's Disease has been taken further by Green and others. They conjecture that a chimera exists between mother and foetus, whereby maternal lymphocytes pass through the placenta into a foetus having only partial immunological tolerance. It is known that red blood cells and tumour cells can pass the placental barrier. Continuing, they suggest that in the presence of maternal cells or foetal lymphoid cells, immunological selection takes place, whereby cells with the fewest or no "identity proteins" will be selected to survive and multiply. These cells become the malignant cells. Their hypothesis was subjected to a measure of experimental testing on the assumption that transplantation antigens of the skin are also present in lymphocytes of the chimeral hosts. Five males with Hodgkin's Disease were homografted with maternal skin, and four of these with unrelated grafts. The latter lasted an average 20 days. One of the homografts lasted well over 30 days, and two homografts lasted for 30 days only. Homografts in Hodgkin's Disease have lasted for more than 30 days in six out of twelve cases of Miller's subjects, ten out of thirteen of those investigated by Kelly, Good and Varco. There is no convincing evidence so far for the survival of bone marrow grafts.

The relevance of homologous disease to Hodgkin's Disease and these immunological concepts lacks at the moment experimental

support. It is considered that the lymphocyte may have a trophic role, carrying D.N.A. to peripheral tissues. This could account for the changes seen in homologous disease in mice. It may be that homologous disease and Hodgkin's Disease represent the terminal results of the same or different aetiological processes. No circulating auto-antibodies to host lymphoid tissue has been demonstrated in Hodgkin's Disease. But, it is to be noted that steroids sometimes cause temporary remissions in this condition. The chimeral theory requires more support from further grafting, both with maternal and paternal skin and investigation of the survival of homografts in all chronically ill hosts. Maternal lymphocytes will also have to be traced to the foetal or newborn circulation.

Investigation into the cause of Hodgkin's Disease has been extensive for more than a century. As yet no one initiating factor has been established, although many possible agents have been excluded. Its aetiology is still in the realm of conjecture and hypothesis. The disease appears not to have an infectious origin, although the difficulties of viral research warrant continued efforts in this field. There is little appreciation of any metabolic or biochemical changes involved, which might prove profitable grounds. The disease has many features of a neoplasm and the continued search into the pathogenesis of malignancy will have relevance here. Mechanisms of cellular behaviour and any trophic role of lymphocytes requires further enquiry. It is intriguing to speculate, although only hypothetically, of a foreign protein—a virus or changed or maternal D.N.A. particles—interfering with the stability of an intracellular protein pattern of the lymphocyte, giving rise to the progressive neoplastic character of Hodgkin's Disease. Craven's remark, although made some time ago, may hold some truth here. "We look upon Hodgkin's Disease as an inflammatory over-reaction on the part of the lymph node structure to various stimuli, a process which, once established, goes on of its own momentum and may even progress to a true sarcoma." As yet, Hodgkin's Disease remains as termed by the French, the "Maladie de Frontiere."

Dental Society Annual Ball

There are still some tickets available for the Dental Society Annual Ball to be held on Friday, 5th November, at the Europa Hotel, Grosvenor Square, W.1. Those people still requiring tickets should apply for them as soon as possible to Stuart Orton Jones, Dental Ball Secretary, Dental Department, Guy's Hospital.

Guy's Hospital Society: Bournemouth and Wessex

The Annual Dinner will be held on Friday, 19th November, at the Heathlands Hotel, Bournemouth. Dr. B. C. Morgan will be in the chair, and any Guy's medical or dental graduate in the area (Hants., Dorset, Wilts., etc.), who has not already been notified by me is cordially invited to attend. Particulars may be obtained from N. J. Wood, 51, Lansdowne House, Bournemouth (Telephone 25847).

CORRESPONDENCE

The Work of the Welfare Centres

SIR,—Dr. Vertue asks what is the future of Salomons Centre. Although Salomons Centre went from Guy's *hospital* in 1948, it continued to be in Guy's, and from the beginning of the N.H.S. the medical officer to the Centre has been jointly appointed by the local authority, and Guy's Medical School and, as at a number of teaching hospitals, the medical officer is also a member of the paediatric department.

Guy's has functioned as a medical school and as a hospital.

On the teaching side, because of its interest in growth and The Child, in prevention, in the comprehensive approach and in measurement, paediatrics makes special contributions to what the students learn. Salomons Centre is essential for the teaching at Guy's.

The functions of Guy's as an area hospital are to-day clearly recognised as well as its being a research centre and a reference centre for cases from the Region (and anywhere in the world). The paediatric staff of an area hospital can make important contributions to the care of local children. The research and clinical work in Salomons Centre make it a centre for L.A. doctors and G.P.s to visit and learn something of new ideas in medicine.

The far-sighted arrangement of 1948 between the Medical School and the Local Authority has been immensely fruitful for teaching and in promoting co-operation between Guy's and the local authority. The answer to Dr. Vertue's last question is surely that, for these and other reasons, "infant welfare in the hospital of Cameron who largely inspired the movement" will continue. A place for this work will surely be found.

Yours, etc.,

RONALD MAC KEITH,
Medical Officer, Salomons Centre.

Guy's Hospital, S.E.1.

The Final Ritual

SIR,—Your remarks regarding the ritual of entry to the M.B. finals are amusing, but the obvious purpose behind it seems to have been missed. In these days of scientific and socialised medicine, it is not sufficient for the aspiring doctor to have a competent knowledge of medicine, surgery, midwifery and pathology; it is even more important that he should possess the savoir faire to cope with the thousand and one forms with which he will be dealing throughout his professional career. Prescriptions, which can no longer simply be written on a sheet of notepaper, certificates of fitness and unfitness, pathology forms, X-ray forms, orders for diets, physio- and occupational therapy, certificates of pregnancy, birth, death and cremation, requests for blood, trusses, wigs, glass eyes and artificial legs. The key to the rich bounty of the Welfare State is the signature of a duly qualified medical practitioner.

Faced with this situation, the University in its infinite wisdom seeks to ensure that all who receive its degrees, whatever defects there may be in their medical knowledge, can safely negotiate the complexities of all these documents.

Bearing this in mind, the candidate will see the need to give serious study to the technique involved. Let him observe carefully how it is done by the most illustrious and prosperous members of our profession. Note the rapid and stylish scrawl, requiring the pharmacist or National Insurance clerk to stretch his imagination to the limit to decipher the information, and to take a chance that the paper is in fact signed by a registered practitioner. With an expert hand, even BLOCK LETTERS may be made completely illegible.

While it is of course advisable that the University be made aware who is seeking admission to an examination, even perhaps which examination, there is no doubt that a certain nonchalance is of value. An air of vagueness, a seemly reserve in disclosing personal details; here as in everything, practice leads to perfection. I myself only succeeded in passing the examination when I forwarded my application, not in a Registered Envelope, Size K, but in one of the common brown variety, in which I had previously received a circular from a drug company, and inadvertently affixed the stamp upside down.

Yours, etc.,

I. A. MACKENZIE.

43, Ynyswen,
Penycae, nr. Swansea.

Just Once and Never Again

SIR,—Your correspondent writing about the recent Cambridge match, says that Guy's have never beaten them. This is not true, as in either 1947-48, Guy's well and truly beat Cambridge. In fact, a reporter was 'phoning in a half-time report when I heard him say, " Hang on! Guy's scored again from the kick-off." Maybe you could reprint the score.

Yours, etc ,

J. M. WOOD.

156, Hendon Lane,
Finchley, N.3.

On 12th November, 1947, *Guy's beat Cambridge University* 15—12.

Old Hat

HATS OFF
TO
GUY'S!
HUNDREDS OF OLD FELT HATS ARE STILL WANTED BY
GUY'S HOSPITAL, S.E.1
FOR WAR-TIME PURPOSES.
IF YOU HAVE ANY TO SPARE, PLEASE WILL YOU SEND THEM TO
THE APPEAL SECRETARY?

SIR,—We have found the enclosed advertisement in *The Church Times,* dated November 24th, 1944. We are both second year student nurses here and wondered if any ex-Guy's staff could explain the need for felt hats at this time.

Yours, etc.,

JUDITH THOMPSON and
CAROLYN SOWDEN.

Nurses' Home,
Guy's Hospital,
London, S.E.1.
19th October, 1965.

Maccabaean Prize and Medal

Entries for the 1966 Maccabaean Prize and Medal are now invited for an essay of 5,000 to 7,000 words on some aspect of the history of medicine or pharmacy. Intending candidates, who must be under thirty years of age on 15th March, 1966, may apply for further particulars to the Hon. Secretary of the Faculty (Dr. F. N. L. Poynter, The Wellcome Historical Medical Library, The Wellcome Building, Euston Road, London, N.W.1.)

REVIEWS

BAILEY AND LOVE'S " SHORT PRACTICE OF SURGERY."

13th Edn. Revised by A. J. Harding Rains and W. Melville Capper. Pp. 1,314. Illus. 1677. *Price* £4 4s. 0d.

The new thirteenth Edition of Bailey and Love's " Short Practice of Surgery" has been ably revised by Professor M. J. Harding Rains and Mr. W. Melville Capper. They have in this edition wisely sought the help of other authorities in revising specific chapters. It is therefore of pleasure to see that Mr. Wass from Guy's has revised the chapter on the Jaw and Professor Atkins that of the Breast. However, the text remains stamped with the original direct and lucid approach favoured by the original authors. It is as complete a summary of surgery as is possible in one text book. Now extending to 1,300 pages, at present it seems to have no rival and can be recommended to both undergraduate and postgraduate reading for the F.R.C.S.

J. C. GAZET.

THE NAILS IN DISEASE

by Peter D. Samman. W. Heinemann. Pp. 130. *Price* 40 *shillings.*

This little book has been based chiefly on the author's personal records of nearly eight hundred patients seen over a period of seven years at various hospitals on account of affections of the nails. It covers all of the common conditions and most of the uncommon ones, too.

The material has been classified in chapters in the traditional manner, and in addition there is a useful section on principal nail symptoms. There is a particularly interesting and lucid account of the anatomy and physiology of the nail. The therapeutic aspect is well covered.

The text is well written in simple English and is profusely illustrated by large clear photographs and four coloured plates. Despite the fairly brief discourse on each disease, the author has succeeded in avoiding the production of a mere catalogue. Some of the credit for this must go to the publisher for the pleasant typography.

Most students and especially those who contemplate General Practice, will find this book interesting and worth reading. The price, however, precludes all but those with dermatological inclinations from purchasing it

GRAHAM SMITH.

"A GUIDE FOR THE MEDICAL SECRETARY",

Heinemann, pp. 81. *Price* 7*s.* 6*d.*

The job of "Medical Secretary" is by definition a highly specialised one demanding, if anything, greater precision and use of initiative than any other branch of secretarial practice. It is surprising, therefore, that no official steps have so far been taken to ensure that those who take up this work come to their duties properly trained and prepared for the vital rôle which they are called upon to play.

This book offers useful advice to the secretary working in any field of medicine, though it will probably be found of more value to those engaged in private or general practice than to those employed in hospitals, to whom the term "Medical Secretary" more generally applies, and a number of the special problems of the latter have not been covered here; those, for instance, which arise as a result of constant secretarial understaffing, and poor "communication" between hospital departments.

For the hospital medical secretary the chapters dealing with "The Patient in Hospital" and "Letters and Reports" will be of particular value. Any secretary may be called upon to assist in the preparation of work for publication and some helpful advice is given in the sections on "Library Work" and "Preparation of material for Publication". For the more enterprising the bibliography provides some useful suggestions for further reading.

There is, unfortunately, missing from the text references to laboratory investigations. Particularly for the secretary in hospital a knowledge of some basic "normal values" and the importance of the more frequently encountered laboratory tests and their significance in diagnosis can increase her efficiency and her status to a surprising degree. Though limited in its scope, this little book is an important first step in encouraging the newly fledged medical secretary to a greater interest in her work and in the value of doing it well.

ELISABETH BERGMAN.

ESSENTIAL ANATOMY,

by Lumley, Craven and Aitken, E. & S. Livingstone Ltd., Publishers. Pp. 357. *Price* 30 *shillings*.

The authors have set out to prepare a revision textbook of anatomy which is complete but brief, avoiding unnecessary detail. Within limits they have been successful and have produced a very useful short account of human anatomy, treating the subject region by region.

The nervous system has suffered most in the attempts at brevity. This is unfortunate, as neuro-anatomy is so important clinically. In fact, the book is quite useful as a revision course for preclinical rather than clinical students.

A. M. MORRIS.

A DENTAL PRACTITIONER'S HANDBOOK, NO. 2.

"GINGIVITIS."

by W. G. Cross. John Wright and Sons Limited. Pp. 44. 52 illustrations. *Price* 9*s*. 6*d*.

The author is to be congratulated on a very clear exposition of his views. The handbook is provided with many clear illustrations that enhance the value of text.

In the section covering acute forms of gingivitis, acute ulcerative gingivitis is fully considered with a useful appraisal of some current methods of treatment even though the use of metranidazole was not discussed. Although acute herpetic gingivo-stomatitis and acute streptococcal gingivitis were enumerated, further consideration was not given to these uncommon though interesting conditions.

This omission is likely to cause a feeling of disappointment amongst readers of the book. When dealing with acute gingival abscess, the need for the provision of a flap operation was mentioned, and it is a pity that the technique was not described as this procedure may sometimes be necessary.

Three subsequent chapters are devoted to various aspects of chronic marginal gingivitis with very valuable emphasis on the early diagnosis and treatment of this condition. Interesting details about instrument design and modifications of instruments in relation to their use are provided, together with an emphasis on the correct sharpening of this equipment. However, the adjustable instrument trolley illustrated is not commercially available.

The final section stresses the need for preventive measures, this is particularly valuable in view of the obvious lack of consideration given to this aspect of dental care.

This publication should prove most useful to general practitioners, dental students and dental hygienists as well as an encouragement in their efforts to further the cause of preventive dentistry.

D. LONDON

SURGERY OF THE ANTERIOR SEGMENT OF THE EYE. Volume 1.

by Barrajuer, Troutman and Rutlan. McGraw-Hill. Pp. 320. *Price* £10.

This volume is concerned with the Operation of Intracapsular extraction. Great advances have been made in this field of surgery in recent years, and the principle author of the book has made a large contribution to them.

The contents essentially comprise a presentation of personal technique, but the subject is most comprehensively discussed, the chapters ranging from surgical anatomy to post-operative care and the management of post-operative complications.

A particular valuable service that the volume renders is to point out that enzymatic Zonulo Lysis should not be considered merely as an adjunct to the classic intracapsular extraction techniques, but that important modifications of technique are essential if the full benefits of the method are to be obtained. Zonulo Lysis and the indication for its use are still a matter of debate for many opthalmic surgeons, but there can be little doubt that a significant proportion of operative and post-operative complications atributed to the use can be avoided if the technique emphasized by the authors is followed.

This volume is a most outstanding contribution to ophthalmic surgery and should be read not only by the experienced ophthalmic surgeons but also by all those in their training period.

C. A. COOK

SPORT

DIARY

Oct. 30.—Rugby Football—Cambridge. Away.
Association Football—Southampton University. Away.
Hockey—Kingston Grammar School. H.O.P.
Nov. 2.—Squash—Bart.'s Cumberland Cup. Away.
,, 3.—Rugby Football—University of London. H.O.P.
,, 4.—Squash—St. Thomas's. At Home.
,, 6.—Rugby Football—Old Blues. H.O.P.
Association Football—Bart's. Away.
Hockey—Imperial College. Away.
,, 9.—Squash—Lansdowne Club. Away.

RUGBY FOOTBALL

In the last edition it was inaccurately stated that Guy's had never beaten Cambridge, and we have been sharply reminded of this fault (see correspondence.) At Honor Oak Park, on 12th November, 1947, we beat Cambridge, who had narrowly lost to the Wallabies, by 15—12. Mr. Lewis appears to have been playing for Middlesex, and the brothers Le Clus seem to have played a major part in this victory. At one time Guy's were 15—0 up, but Cambridge came back with a try, a penalty and a dropped goal. At that time, when the correspondence columns of the *Gazette* were filled with letters about the National Health Service, a wise correspondent wrote, " Nobody can deny that this performance by the Hospital stamped them as a good all-round team, fully justifying all the high hopes of the captain, H. Brunow." His hopes were fulfilled, for later in the season, Guy's beat Mary's in the Cup Final. That was a good season for Guy's—we beat Coventry, Bedford and Rosslyn Park, and two players, T. Lewis and J. Keeling had trials for England.

Since the last edition, Guy's have played two games. We lost 13—25 to a strong Bedford side, who beat Cambridge a week later. Against Cheltenham, a considerably weaker side, Guy's put up a poor performance, losing 14—3.

R. Kerner, who has played 3 full seasons for the first XV, and started off this season, has now left Guy's. Kerner was a tough and hard-running wing, who scored many fine tries, and his place will not easily be filled.

BOXING

On October 12th, Guy's visited R.M.A., Sandhurst, for the annual match in conjunction with the Belsize Boxing Club. There were nine bouts during the evening, three of which featured Guy's fighters.

The first was between Wyatt, of Sandhurst, and D. Edgar, of Guy's. Wyatt looked extremely fit, as did all his team, and Edgar, whose fitness was in doubt, wisely played a waiting game in the first round. His reach was superior, and each time his opponent came in, Edgar put in an accurate left and scored valuable points. In the subsequent rounds, Wyatt was much more aggressive, and it took all Edgar's skill and indeed all his energy to prevent him getting on top. When the bell went, Edgar was extremely tired, but had put up a skilful performance and deserved his victory.

Pearce, of Sandhurst, fought R. Stansfield, of Guy's, in the heavyweight division. Stansfield met a barrage of hard and telling punches as he advanced from his corner, and was a little bewildered for much of the first round. However, thereafter he more than held his own and one felt that had he been a little more aggressive with an opponent no more experienced than himself, he could have won the fight, but the decision went against him.

By far the most skilful and entertaining bout of the whole evening was the last, a light heavyweight fight, with W. Onyeama, the Guy's captain, and P. Bird, of Sandhurst, who was obviously the local hero. Both fighters looked extremely fit, as Bird entered the ring to enthusiastic cheers. Bird was a good bit heavier and obviously had a bigger punch, but Onyeama displayed some very agile ducking and weaving. Although Onyeama was his equal in the first, Bird got in some good punches later on, and his superior fitness eventually won him the fight.

The evening produced some good amateur boxing, Sandhurst eventually winning the match 5—4. Afterwards we were entertained to supper and beer in the dining hall.

REPORTS & RESULTS

RUGBY FOOTBALL

GUY'S v. U.S. PORTSMOUTH

At Portsmouth. 2nd October, 1965
Result: lost 15—13

Guy's travelled to Portsmouth for this game on a day when there was sunshine and only a little wind.

The game began disastrously for Guy's. From the start the handling of the ball was poor, as was the kicking, and only some good anticipation and covering prevented the opposition from scoring. The score opened after 25 mins. with a try by the Portsmouth scrum-half, which was converted. From this point Guy's game became more determined and constructive, and their efforts were rewarded when Beacham made every use of a loose ball to break away, running half the length of the field to score a try under the posts. This was quickly converted, but to everyone's amazement, on the field, and in the stand, the referee did not allow the conversion.

Half-time: 5—3 down

The second half began with some enterprising rugby from both sides, but again it was U.S. who scored first with a converted try after a mistake by the Guy's defence, after 10 minutes play. 10—3 down.

From this moment Guy's took command and began to move the ball well and to use their wings, for the middle was closed by a very good U.S. full-back. After 20 minutes, Morris received the ball from a scrum, passing to the right, starting a very constructive move which ended in a fine try by Kerner, which was converted. 10—8.

Play switched from end to end, and five minutes later, after a scrum on the right, the U.S. scrum-half received the ball and moved it to the left where it was kicked ahead over Guy's defence, and a very good try was scored. 15—8.

Now Guy's realised that they could win this game and began to use the ball well, playing the better rugby, and entertaining the spectators with some exciting moves. Sharp came very close to scoring, but some harsh refereeing deemed there had been a knock-on.

About eight miniues from time, an excellent run, started by Rowlands, split the defence. He passed to Edgar, who had Kerner on his outside. This ended in a good try near the touchline when Edgar lobbed an accurate pass to Rowlands for him to go over. Morris converted a very difficult kick. 15—13.

Guy's pressed on with all they had got, but were to lose the game. They had played very well after a shaky start, and were foiled by some excellent full-back play and by the outstanding U.S. scrum-half.

Team: Morris; Kerner, Edgar, Beacham, Ross; Rowlands, Moore; Davies, Gibson, Stansfield, Cockburn, Peace, Sharp, Neville, Williams.

GUY'S v. CAMBRIDGE UNIVERSITY

At Cambridge. 9th October, 1965
Result: lost 26—3

The Guy's side for the annual visit to Grange Road showed a number of changes in the forwards from that which lost narrowly to U.S. Portsmouth the week before. Lewis, Kingdon and Brown returned to the side to the exclusion of Gibson, Peace and Neville. The University side included two Irish internationals: Gibson at stand-off, and Doyle at open side wing-forward.

With the sun shining and the pitch in perfect condition, the large crowd looked forward to a fast, open game, and as it turned out were not to be disappointed.

The Hospital went all out for an early lead, but a good threequarter movement and attempted drop goal came to nought, and a dangerous loose rush was thwarted by the Cambridge full-back fly-kicking into touch. Cambridge soon settled down, and astute kicking by the half-backs and strong running in the centre, took them into the Guy's half. This was to be the pattern of Cambridge play throughout the first half and brought them three tries before half-time, two of which were converted. One of them showed Gibson at his best, when he split the Hospital defence with a run of 50 yards to score near the posts. The other two came from well-placed kicks, aided by favourable bounces and slow covering in defence. The Cambridge full-back also dropped a goal from 35 yards when a clearance failed to find touch.

Guy's came into the game more just before half-time and should have scored with a penalty attempt from 35 yards. Ross showed that he had little respect for the reputation of his opposite number in making two typically determined runs up the wing. Although there was some good work by the forwards, the back play was often indecisive, or poor kicking gave the Cambridge defence time to clear their lines with interest.

Half-time score: Cambridge Univ. 16, Guy's 0

In the second half Cambridge went further ahead with two more good tries, both of which were converted. Morris, who had been doing some fine touch kicking with both feet throughout the match, opened the scoring for Guy's with a long penalty goal.

Cambridge began to show signs of tiring in the last quarter, and Guy's showed new life, coming close to scoring on a number of occasions. Morris hit the post high-up with a good attempt at a drop-goal, Brown was twice stopped short of the line by the full-back, and Sharp (who moved to the wing when Kerner left the field with an ankle injury) made a spirited dash up the wing with Edgar in support. Two other chances were squandered when vital passes were dropped in favourable scoring positions. However, the Cambridge defence managed to survive all attempts to reduce the arrears, and at no side the score was 26 pts. to 3 pts. in their favour.

B.J.R.

GUY'S v. BEDFORD

At Bedford. 16th October, 1965
Result: lost 25—13

Last Saturday, both the 1st and "A" XV's travelled up by coach to Bedford; the "A" having to embark on a hurried lunch as their kick-off was scheduled for 2 p.m. The 1st XV players were spectators for the first 20 minutes or so of that game, and as they left to change for their big match, the score was nil all, and the seconds were playing with great spirit and determination.

Guy's won the toss and decided to play against the 'notorius slope' on the Bedford pitch. Bedford attacked unremittingly for the first 20 minutes, but were held out by a determined defence; both the back row and the threequarter line doing sterling work. Then it was Guy's turn to attack, having quenched the storm. The pack were playing well together; Cockburn and Kingdon doing well in the line-outs, and Lewis holding his own in the

set pieces. Play fluctuated to and fro for the remainder of the half, and at half-time Guy's were trailing 9—5; the Hospital's score resulting from some good work by the back-row, notably Sharp and Thorburn; the latter, playing his first game for the Hospital, scoring the try underneath the posts. Morris converted.

Unfortunately, in the second half, instead of pressing home the advantage of playing with the slope, Guy's found themselves on the defensive. The pack lost its cohesion of the first half and the half-backs persisted in kicking unintelligently, which later on resulted in Bedford scoring two of their tries. From a high kick, underneath his own posts, Morris appeared to mark, but the Bedford pack pounced quickly and their effort resulted in a try underneath the posts, which was converted.

Guy's retaliated immediately during one of their sporadic bursts of brilliance, Thorburn, picking up in midfield, weaved his way past half-a-dozen defenders, and with some good interpassing amongst the forwards, the move ended with Ross going over in the corner. Morris failed to convert.

After this, as mentioned earlier, the Bedford left wing scored two tries, which he snapped up as a result of some unintelligent defensive kicking. However, Guy's finished strongly as they have done in each of their last three games against formidable opposition, and Bundred finished off an opportunist break by Rowlands to score near the posts. Morris converted.

In conclusion, one can only say that after half-time Guy's failed to press home the advantage they had strived so hard for in the first half, and as a result lost by a clear margin.

J. E. DAVIS

GUY'S v. CHELTENHAM

At Cheltenham. 23rd October, 1965

Result: lost 3—14

After several good games recently, Guy's were disappointing at Cheltenham and lost by a penalty goal to a goal, two tries and a drop goal. The Hospital side showed several changes: G. Thomas returned to the left wing, having last appeared for the Hospital nine seasons ago. Two freshers, D. Elliot and M. Cheeseborough, were introduced at full-back and fly-half respectively.

The game opened with C. Lewis winning the first two scrums "against the head", which looked a good omen. In fact, after the first five minutes, Guy's had a constant territorial advantage for at least half of the first period No score came, however, as so often a hindered delivery from scrum and line-out caused further mistakes at half-back and delay in the three-quarters while the Cheltenham defence was allowed to advance and consolidate. Beecham and Thomas were able to carry the ball some way down the wing on several occasions, but the moves petered out from lack of support. Having frustrated the Hospital's attack for so long, Cheltenham began more easily to seize on Guy's handling mistakes. Play was taken to the other end and the home side scored a try just before half-time.

In the second half, further handling mistakes allowed Cheltenham to turn attacking positions, hardly earnt by the Hospital, to their own offensive advantage. Near the Hospital's line, indifferent tackling gave Cheltenham an increased lead. Indeed, but for a careful and steadfast performance at full-back by D. Elliot, who gained the respect of the crowd, the Hospital's defeat may well have been greater.

Team: D. Elliot; J. Ross, J. Edgar, R. Beecham, G. Thomas; M. Cheeseborough, B. Moore; J. E. Davies (Capt.), C. Lewis, R. Stansfield, M. Cockburn, A. Kingdon, H. Sharp, K. Brown, P. Williams.

I. A. BAKER

CROSS-COUNTRY

Prospects for the season looked good when an unprecedented number of nine had been out training a fortnight before term started, and six freshers and four older members joined the club. Brian Smith and Geoffrey Waterhouse have shown great promise already. Enthusiasm is high, and provided that everyone can run regularly despite exams and Wednesday afternoon commitments, we should have our best team since eight years ago. P. Witting ranks among the top University runners.

Results:

9th October—1st University Trial.

P. Witting, 4th.

B. Smith, 37th.

20th October—v. Latymer School at Hammersmith.

1.	P. Witting.	8.	D. Vernon.
2.	B. Smith.	10.	D. Halestrap.
6.	G. Waterhouse.	11.	B. Avery.
7.	E. Bowen-Jones.	12.	J. Wheeler.

Guy's won 33—44.

ASSOCIATION FOOTBALL

London University Cup

GUY'S v. BIRKBECK COLLEGE

At H.O.P. 24th October, 1965

Result: lost 1—7

The story of Guy's football this year has been one long tale of woe, and never more so than last Saturday. Against a Birkbeck side, who were nothing better than moderate, Guy's succumbed and were heavily defeated.

That Guy's are no longer the team they have been is an inevitable consequence of losing several outstanding and experienced players, and the Hospital's feat in reaching the semi-final stage of this competition for the last two years was hardly to be expected this year. However, having allowed for this, the side's performance on this occasion was greatly disappointing.

Having delayed the start for twenty minutes in the vain hope that two members of the side would arrive for the kick-off, Guy's were forced to start with nine men, and were soon in arrears. Early in the second half Guy's scored to make the score 2—1, and for a period it looked as though the tide was going to turn in their favour. However, a succession of blunders by the home side and praiseworthy opportunism on the part of the Birkbeck forwards saw the game slip irretrievably from the Hospital's grasp. The defence became indecisive in their tackling and clearing so that the opposing forwards were usually given several bites at the cherry.

The report may appear harshly critical, but to the writer's mind it has to be so in order to classify as a report on the game. Having said that, it must also be said that despondency over the prospects for the remainder of the season is not entirely warranted. The side is capable of far better displays than that provided on Saturday, but at the moment it seems that nothing will go right. Inevitably, the confidence of the side has been blamed, thus completing a vicious circle by spoiling many players' performance; only J. Powell-Jackson being exempt from any criticism on this occasion. It is to be hoped that Guy's will achieve a couple of wins in the near future, thus restoring sufficient confidence for the team to make a genuine impact in its assault on the Inter-Hospitals' Cup.

ELWYN ELIAS

HOCKEY

GUY'S v. ROMFORD

Away 16th October, 1965

Result: won 2—1

Played in glorious sunshine on a soft pitch in Essex, Guy's deservedly beat a strong Romford side. Romford started the game as though they were playing football and came close to scoring after they had kicked the ball into the circle. From this and a few other incidents it was soon clear that the only rule the umpire knew was the new sticks rule, and even then he was uncertain about it at times! However, the other umpire was more capable and prevented the game from going too much out of control.

The Guy's forwards played constructive hockey and went near to taking a lead on several occasions. In defence, Rear, Crafts and Kendrick all played well, with Rear outstanding.

In the second half, immediately following a Romford attack, the ball was cleared to Godfrey who, after a good run on the wing, centred the ball perfectly for Bennett to finish off the move with a well taken goal. Appleby and Cripps also went very close to scoring when their shots just missed by inches. However, it was Bennett again who increased the lead. This prompted Romford into a final all-out attack in an effort to save the game, and in this they nearly succeeded when they scored with a good penalty flick. They continued to press hard but the Guy's defence held firm, with Rear bringing off some brilliant saves until the final whistle went.

Altogether a very encouraging effort, which augurs well for the rest of the season and the Inter-Hospitals' Cup.

Team: S. Rear; D. Loader, R. Kendrick; J. Crafts, C. Brooks (Capt.), R. Jenkins; A. Godfrey; S. Cripps, M. Appleby, P. Bennett, C. Pearson.

GUY'S v. H.A.C.

At H.O.P. October 23rd, 1965

Result: won 3—2

Guy's played some good hockey in the first half, and with a little luck and some better finishing, could have scored several goals. However, at half-time the score was 1—1, Bennett having beautifully converted a right-wing cross, and the H.A.C. equalising through a penalty flick awarded after a goalmouth scramble.

On the whole, Guy's were on top in the second half, and scored two more goals; Cripps touched in a cross from the left, and Bennett converted a penalty flick. H.A.C. scored their second goal minutes before the final whistle.

This was a good game, encouraging for Guy's from many aspects. The forwards combined well, Pearson and Bennett forming a very effective left-wing pair, and the defence was sound. However, the fact remains that Guy's should have won by a wider margin; the forwards missed several good opportunities which will have to be taken in the ensuing Cup games.

M. APPLEBY

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, LONDON, S.E.1.

Applications are invited for the following appointments in the **Department of Conservative Dental Surgery,** commencing on the 1st January, 1966, or as soon thereafter as possible:

Full-time Registrar.

Registrar to attend on five sessions per week until 31st July, 1966.

Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, London, S.E.1, not later than **Monday, 15th November, 1965.**

BEXLEY HOSPITAL, DARTFORD HEATH, BEXLEY, KENT

(14 miles from London—good transport available.)

Senior House Officer in Psychiatry required from 1st November, 1965. Single or married accommodation available. Bexley Hospital has over 1,900 beds dealing with all types of psychiatric illness. Experience available in modern physical, occupational and psychotherapeutic procedures. Duties will be at Bexley Hospital for six months and at the Psychiatric Unit, West Hill Hospital, Dartford, for six months. Hospital recognised for D.P.M., Clinical Instruction, Tutorials in Psychology given, and facilities exist for attending D.P.M. courses. Applications, giving two referees, to Physician Superintendent, within ten days.

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PRIZE LIST

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PERSONAL

Guy's dental surgeon practising Bournemouth would welcome associate. Excellent facilities, staff and a full body. Full details from Appointments Bureau, Guy's Hospital, or Box No. 36.

BIRTHS

WILLEMS.—On October 13th, 1965, at the Churchill Hospital, Oxford, to Annette (née Rake) and Anthony Willems, a daughter, Juliette Miranda, a sister for Caroline and Isabelle.

VADASZ.—On 19th October, 1965, to Carolyn and Imre Vadasz, of the Willow House, Church Lane, Trottiscliffe, Nr. Maidstone, Kent, a son, Nicholas, a brother for Anthony and Sarah

ENGAGEMENT

Keith Geoffrey Isaacson (Dental School, 1954-60) to Jennifer Rosemary Townsend (Medical School, 1960-65).

CHANGE OF ADDRESS

Mr. and Mrs. J. E. C. Weddup, Easterbrook, Roadwater, Watchet, Somerset.

EDITORS P. BOWDEN AND A. E. RAYNES
SPORTS CORRESPONDENT A. PROCTER
FORTNIGHTLY TWO SHILLINGS VOLUME 79 NUMBER 2016

PASSIM

Guy's Hospitals

On October 21st, 1965, the Ministry of Health issued the following press announcement:—

"The Minister of Health has decided to unify under the Board of Governors of Guy's Hospital the administration of Guy's Hospital and the hospitals now administered by the Bermondsey and Southwark Hospital Management Committee. After 1st November, 1965, the Board of Governors will be responsible for providing hospital and specialist services for the area."

This is only part of a larger scheme to re-organize the control of the hospital services in London, which envisages integration of the teaching and regional hospitals into comprehensive teaching hospital groups, each responsible for providing complete hospital services for their area. The decline in the residential population in the central London areas and the wealth of hardly tapped clinical teaching material in the regional hospitals makes the new move a logical progression from the teaching point of view. The scheme will make more beds of different sorts available for teaching and will inevitably widen the undergraduate's clinical experience. The method of selective admissions practised by the teaching hospitals has tended to give the student a somewhat unbalanced picture of hospital practice and has shielded him from certain kinds of medical problems, especially the nursing of the long-stay patients. The new scheme will give the student opportunity to experience all aspects of a complete hospital service to a community.

The increase in the number of available teaching beds will also provide facilities for the necessary expansion in the medical schools. The difficulties in producing more doctors from the London teaching hospitals would now seem to lie in the ability of the preclinical departments to meet this new potential in the clinical years. A similar increase in accommodation for these departments would have to be found if this is to be achieved.

Under the new scheme it is expected that the teaching hospitals will have to adapt themselves more to their immediate catchment areas and accept more local patients. This would improve the association between the teaching hospital and the immediate population. However, the concentration of specialized and research units at teaching hospitals demands a certain degree of selection of patients, and unless these units are resited at the regional hospitals, this will hardly be influenced to any degree. If the new organization recognises the higher demands of the parent teaching hospital, then there need be little fear that the scheme will impinge on the inherent character and spirit of the London teaching hospitals.

Guy's, St. Olaves and New Cross Hospitals

Under the amalgamation scheme, Guy's, St. Olave's and New Cross Hospitals are now one unit.

The teaching of medical students calls for physical facilities apart from the mere presence of a teacher and patients. To this end, arrangements for student accommodation at St. Olave's are well in hand. Dressers in the Obstetrical and Gynaecological department now have the opportunity to attend out-patient and operating sessions. The help that has been given to candidates for the final F.R.C.S. examination in the past will continue, but in addition, an undergraduate surgical firm will have opportunities for clinical work. On the medical side it is hoped very soon to establish regular clinical teaching on similar lines at St. Olave's. New Cross Hospital, with its special departments, will provide particularly for teaching in Physical Medicine and in Geriatrics.

In future, house appointments at Guy's, St. Olave's and New Cross will all be made at the same time by the Guy's Medical Committee. That Committee will be comprised of the members of the Staff of all three hospitals, so that it will become commonplace for a house officer to move from an appointment at one of the hospitals to a subsequent appointment at one of the others. In this way the integration which has started with the consultant staff will spread throughout the whole structure of the new expanded hospital unit.

The Psychological Society

At a time when grumbles about student apathy and lack of initiative are heard *ad nauseam* and cynicism is preached with depressing universality, it is a relief and a pleasure to be able to record the birth of a new Society at Guy's.

The neonatal Psychological Society promises to be of great interest; like the Physical and Physiological Societies, it affords, among other things, extracurricular support to the teaching system but in this respect, it has chosen a field which is given very little time in the present medical course. Thus it should attract student audiences from both sides of the park and perhaps do something towards narrowing the academic and social gap that exists between the preclinical and clinical years.

Whatever it achieves, it is currently setting an encouraging pace with its first meeting attracting one of the largest audiences at Guy's for some time. We wish it many similar successes in the oncoming years, and a long and interesting existence.

Professor Hedley Atkins will deliver the Bradshaw Lecture at the Royal College of Surgeons of England, Lincoln's Inn Fields, W.C.2, at 5 p.m. on Wednesday, 8th December. The title of this lecture will be "Cancer of the Breast".

GUY'S DIARY

NOVEMBER

Exhibition.			Fractures of the Spine.
15th	M.	1.00	Clinical Lecture. Dr. BAKER. "The Use and Abuse of Digitalis".
15th	M.	4.30	Applied Physiology Lecture. Dr. D. C. DEUCHAR. "Heart Sounds and Murmers".
18th	Th.	4.15	Physiological Society. "Placental Circulation". Speaker: Mr. D. A. G. BARFORD. Chairman: Mr. F. M. SULLIVAN.
18th	Th.	5.00	Neurosurgical Round. Mr. P. SCHURR. Clinical Theatre.
19th	F.	1.00	Clinical Lecture. Dr. TROUNCE. "Renal Tract Infections".
22nd	M.	1.00	Clinical Lecture. Mr. BATCHELOR. "Injuries and Abnormalities of the Neck".
22nd	M.	4.30	Applied Physiology Lecture. Dr. D. C. DEUCHAR. "Cardiovascular Pulses".
23rd	Tu.	1.00	Clinical Lecture. Dr. MANN. "Haematemasis and Melaena".
23rd	Tu.	4.15	Experimental Psychology Lecture. Mr. M. F. PIERCY, M.A. (of the Maida Vale Hospital for Nervous Diseases). In the Physiology Theatre.
25th	Th.	1.00	Clinical Lecture. Mr. GLOVER.
25th	Th.	4.15	Physiological Society. "Face Anomalies". Speaker: Mr. P. M. CARTER. Chairman: Mr. P. W. CLARKSON.
26th	F.	10.30	Experimental Psychology Lecture. Mr. M. F. PIERCY. Physiology Theatre.
26th	F.	1.00	Clinical Lecture. Dr. SCOTT. "Endocrine Causes of Hypertension".
27th	S.	10.00	Clinico-Pathological Meeting will be held in the Clinical Theatre.
29th	M.	1.00	Clinical Lecture. LORD BROCK. "The Management of Pleural Infection".
29th	M.	4.30	Applied Physiology Lecture. "The Analysis of a Patient with Cardiovascular Disease". Dr. D. C. DEUCHAR.
30th	Tu.	1.00	Clinical Lecture. Dr. MACKENZIE.

THE ELDERLY PATIENT IN GUY'S

PATRICIA CORBY — **Supervisor of Student Unit, Dept. of A.I.M.S.W.** — **Medical Social Work, Guy's Hosp.**

MARY BAKER-ROGERS
MARY ELFORD
JEAN MEYRIC-HUGHES
ANNE VENUS — **Students - Younghusband Course Croydon Technical College.**

Four general Social Work Students from the Younghusband Course at Croydon Technical College have spent nine months since September, 1964, carrying out a fieldwork placement in the Student Unit of the Department of Social Work at Guy's. In order to help them gain some understanding of the broader social work issues, such as research and social action, it was decided that it would be helpful for the students themselves to carry out a small survey.

CHOICE OF PROJECT

In recognition of the fact that the elderly in-patient in a teaching hospital poses a number of problems for staff in all spheres—medical, nursing, administrative and social work, it seemed appropriate to choose our area for investigation here. We therefore chose as our terms of reference:—

> **"A feeling exists in Acute Hospitals that elderly patients block beds. Is this supported by evidence found in an investigation of all patients over 65 years admitted between 11th January and 2nd April, 1965, to one Medical Unit and the Orthopaedic Accident Unit at Guy's Hospital?"**

METHOD

Considerable preliminary work was done through discussion with various members of the ward staff. From this it seemed clear that it would be helpful to carry out a small pilot survey and, to this end, all elderly patients (over 65 years) admitted to Dr. Baker and Dr. Houston's beds were interviewed during a four-week period in November, 1964. Following this, a discussion was held with the Ward Sisters and Housemen concerned, which proved most helpful and clarified many points.

It was then decided that the period for the main investigation should be January/April, 1965. In making this decision we acted on the presumption that these were likely to be the heaviest months for the admission of the elderly. Whilst realizing that it could not provide a control, in the true statistical sense, it was felt it could be helpful to have something with which to compare our findings. It was therefore decided that Miss Wood (Social Worker for the Dr. Hardwick/Dr. Trounce firm) should make a note of the admissions of the

elderly to those beds, and also that she would note the type and method of referrals made to her in the normal way for social work assistance.

In our discussions following the pilot study, it became clear that a decision about "delay" was bound to be subjective but that we could attempt to offset this through a discussion between social work student, Houseman and Ward Sister. We concluded that "delay" would have occurred if the patient was unable to be discharged following the Houseman's decision that the patient was medically ready to leave the hospital. We categorised "delay" into three types—administrative, social, and emotional. In fact, we found that it was necessary to have many discussions with the Housemen and Ward Sisters, both in general and over individual cases, and it was only through their willing and ready help that we were able to carry out the investigation. In addition to these discussions, Dr. Spurrell gave freely of his time to help the students understand the medical conditions and the implications of these for the patients' everyday living.

Between them the students interviewed all the elderly patients admitted to the chosen wards for the period under review. These interviews were similar to the usual assessment interviews that any Medical Social Worker would carry out when a patient is referred for help. The only exceptions to these full interviews were where the patient was inaccessible because of disorientation, deafness or speech difficulty. There were some cases where the patient died before an interview was possible. In many cases relatives were also interviewed. Where the students, in their assessment interview, discovered social need they proceeded to deal with this as they would have done had the patient been referred for help through the normal channels.

We decided that it would be relevant to make a decision about the category of illness from which the patient suffered and also whether the ill-health was chronic, malignant or acute. In our assessment of the patient's social situation we took into account housing, finance, effective relatives, interests outside the home, attitudes (to illness, hospital, future, etc.) and the availability of community support, both statutory and voluntary (Home Helps, Meals on Wheels, Clubs, and official visitors from such bodies as the Old People's Welfare).

We were interested to know whether there is any degree of pre-selection in the type of case admitted to Guy's (in comparison with local general hospitals)—but found it very hard to discover if this takes place.

We caught a glimpse of the difficult situation which can arise in Casualty where, in many instances, the main burden of decision about the rightful place for the elderly sick seems to be taken. In a great many instances it seems that the elderly sick are felt to be a problem the moment they are admitted to hospital for fear is immediately felt that it will prove difficult to achieve their discharge.

FINDINGS

In all, sixty-one patients were assessed. On Hurst and Bright, 32 patients were seen; average age, 70.5 years; 14 women and 18 men—15% of the total admissions for that period. On Christopher,

29 patients were seen; average age, 76.8 years; 20 women and 9 men—19% of total admissions.

No patients were admitted from the Waiting List and it seems that the elderly come into hospital in the main through negotiation with the General Practitioner; direct from Out-Patient Clinics, or via Casualty. The majority of patients came from the immediate district (S.E.1 and S.E.16) but a sizeable number (20) came from places as far away as Kent and Essex.

We observed that, in the main, the patients admitted to Christopher had usually been "fit" until admission, whereas in Hurst and Bright, this admission was more often one of many in an overall pattern of declining health. We had anticipated that, for the elderly a stay in hospital might make a difference in their ability to maintain a home. In fact, this was not so. Permanent change of circumstance came about in only seven cases. It surprised us to discover that "delay" in fact occurred in remarkably few cases and, in our sample, rarely on account of social difficulties. In fact we had:—

Hurst and Bright:

1 administrative delay ..	18 days
1 social delay	14 days
1 Medical/emotional delay ...	7 days

Christopher:

1 administrative delay ...	7 days
2 emotional delays	7 days and 10 days
1 social delay	4 days

EXAMPLES

Social Delay

Mrs. Z., 69 years, admitted with fractured tibia and fibula. Before admission lived alone. Patient, when ready for discharge, felt she would manage satisfactorily with Home Help and Meals on Wheels. Relatives concerned at her being alone. A few days' delay occurred whilst the relatives arranged a rota of visitors to keep an eye on Mrs. Z until she was more mobile.

Administrative Delay

Mrs. X, 82 years, had previously spent a number of months in Guy's following a cerebral vascular accident. She was discharged to New Cross Geriatric Unit and subsequently returned home, where she managed satisfactorily for some considerable period. Re-admitted following further collapse. Seen by Dr. Rosin—delay of 18 days before suitable vacancy available for re-admission to New Cross.

Emotional Delay

Mr. Y, 65 years, was admitted with chronic bronchitis. Social Worker was informed that the patient was ready for discharge. After being told of his impending discharge, Mr. Y. became acutely breathless. There seemed ill-defined physical causes for this and anxiety appeared to be playing a large part in his condition. The Social

Worker investigated and found that things had been difficult for Mr. Y before his admission because of his mentally confused state. His wife, an isolated, dependent woman, had relied almost entirely upon him, to the extent that she was unable to go out of the flat without him. It seems that illness finally tipped the balance in his ability to cope with the situation and, faced with discharge, he took refuge in his condition. Providing him with support from the community via the Mental Health Social Worker, enabled him to leave the hospital.

Mention should, perhaps, be made here of one patient in Hurst Ward who was admitted a day or so before the start of our survey, and still remains there, awaiting a bed in New Cross Geriatric Unit. The administrative delay here has lasted three months so far. By virtue of her date of admission she just failed to become eligible for our investigation.

Administrative delays occurred through the waiting list for admission to New Cross Rehabilitation or Geriatric Units. In the two cases of social delay this seems to have been caused because relatives had not been fully aware of the imminence of the patient's discharge. There are, possibly, a number of causes here—one of which could be because the relatives themselves had not really been able to listen to explanations. In both cases, once the situation had been clarified and the relatives felt they had some support in facing the renewed task of caring for their elderly parents, things fell into place and they were ready to take the patients home.

Further Examples

Mrs. U, 90 years, was admitted following a haematemesis. Five weeks later the House Physician said she could be discharged but would not be fit to live alone. The daughter said she could not cope and a crisis developed. Social Worker asked the House Physician to keep Mrs. U. in whilst she discussed the situation with the patient's daughter. When the daughter found the social worker accepted that she was faced with a difficult situation she relaxed and began to think more positively. Through discussion she was able to get her problem into perspective—and then felt able to have her mother to live with her.

In this investigation we have been very struck by relatives' attitudes and have not found confirmation of the fairly widely held view that relatives wish to "dump" the elderly in hospital and thus absolve themselves from personal responsibility for their care. It became plain that, where the care of the elderly sick is concerned, the staff and public hold widely differing views of the hospital's rôle. The public take the view that the person is very sick, therefore needs the care and attention of the hospital, and indeed, the local residents feel that Guy's is their natural haven in illness. The members of the hospital staff, whilst seeing the patient's need, fear misuse of their highly technical skills and facilities and realise they must maintain a supply of satisfactory teaching material for students. These diverse

views can, on occasions, lead to a tense situation arising between the patient's relatives and the admitting staff, in which both sides can feel compelled to over-state their case; thus making resolution of the problem more difficult. In fact, we found that many relatives, although caring for the elderly under extremely difficult circumstances, showed little desire to divest themselves of their responsibilities.

> Mr. P, 69 years, was found, on admission, to have carcinoma of the bronchus, and a lobectomy was performed. His wife had had many years caring for him as he had never got on top of things after a partial gastrectomy ten years ago, and his recovery had been complicated by the fact that he also suffers from pernicious anaemia. He is a slow, rather trying man. In addition to her husband, Mrs. P. cares for her 93-year-old bedridden mother. They have poor home conditions as they live in a decaying house in a demolition area. Despite her own exhaustion, Mrs. P. unquestioningly accepted her heavy burden when her husband came to be discharged.

It was also notable how great a relaxation in relatives' attitudes occurred once they felt that their own difficulties, as opposed to those directly appertaining to the patient, were appreciated. The recognition by a member of the hospital staff that they too had a problem seemed, in many cases, to lead to their greater willingness to continue to care for the elderly.

> Mr. S., 68 years, became dramatically ill with a spontaneous pneumothorax. His wife was thrown into a panic because she felt responsible for his ill health and concerned that climbing the many stairs to their fourth floor flat might cause a recurrence of her husband's ill health. Mrs. S. had had treatment in Cane Hill Mental Hospital and was used to relying on her husband's support. She needed help in containing the anxieties aroused in her by her husband's illness and assistance in dealing with the Housing Authorities.

Twenty-six elderly patients were admitted into Dr. Harwick and Dr. Trounce's beds. There were no diabetics amongst the patients in our survey, but otherwise the disease spread appeared similar.

The outstanding difference between the two units seems to be in the number of patients apparently requiring social work help. Two patients were referred for help in the control, whereas the students took on thirty cases for social work assistance via the survey. It is hard to understand fully the causes for this but it seems possible that a number of factors may be involved. Needs undoubtedly could vary in different units. On Hurst, Bright and Christopher, because of the survey, everyone became particularly aware of the social problems. Time for students is more elastic; they are eager and enthusiastic to help their patients and will go to considerable lengths to do so. We noticed that on Christopher, by nature of the patient's physical difficulties the social need was seen to be closely connected with the patient's medical care. Here, too, the physiotherapist seemed to play some considerable part in assessing social need.

Mrs. H, 71 years, admitted with a fractured tibia and fibula. Because the ward staff could immediately see that, on account of physically unsuitable conditions at home, she would be unable to manage alone whilst in plaster, action was, in the early days, taken to discuss Mrs. H's future with her son. He was willing to have her to live with him. Although anxious about this, the patient agreed to stay there temporarily. When the time came, her discharge went smoothly.

We were interested in the comment of one House Physician. He told us that he thought of the patient's domestic situation when admitting; forgot it in the urgent need for attention to physical disease and treatment; then, once he was ready to discharge the patient, realised, with a shock, that the social situation was relevant.

CONCLUSIONS

Whilst realising that, because of the small numbers and lack of effective control, we are not in a position to make any statement bearing statistical weight, this investigation has high-lighted a number of aspects of the care of the elderly in hospital.

It would appear, from this limited investigation, that the feeling that the elderly sick remain in hospital much longer than is medically necessary is exaggerated. It seems possible that, in the few instances where this does occur, concern and frustration is caused far beyond that merited by the numbers actually involved.

From the point of view of providing an effective social work service we are left speculating whether this investigation might be used as a basis for another look at referrals to the Department. Casualty does seem to be a place where hospital and community clash in their attempts to look after the elderly sick and we wonder whether we might conduct a limited investigation of social work need here, which might be a step towards relieving the situation in some small way. The figures on which this report has been based can be seen in the Appendix.

We would like to conclude by thanking the ward staff and many others who have made it possible for us to carry out our investigation.

APPENDIX

1. NUMBER OF PATIENTS—SEX—AVERAGE AGE.

	Number of Patients	Men	Women	Average Age	Men	Women
Medical Unit	32	18	14	70.5	69	72
Orthopaedic Unit	29	9	20	76.5	76.7	76.9
Control	26	12	14	73.5	73	74
Totals	87	39	48			

2. MARITAL STATUS OF PATIENTS.

	Married	Widowed	Single	Men			Women		
				M	W	S	M	W	S
Medical Unit	17	13	2	14	4	0	3	9	2
Orthopaedic Unit	8	20	1	4	4	1	4	16	0
Control	13	12	1	10	2	0	3	10	1
Totals	38	45	4	28	10	1	10	35	3

3. DIAGNOSIS—PATIENTS IN MEDICAL UNIT.

Diagnosis—Medical Unit	Total	Men	Women
Cerebro-Vascular	4	1	3
Respiratory	5	5	–
Cardio-Vascular	11	7	4
Carcinoma	6	4	2
Gastro-intestinal	3	–	3
Neurological	1	1	–
Minor Acute	1	–	1
Attempted suicide	1	–	1

Type	Total	Men	Women
Chronic	13	7	6
Acute	13	7	6
Malignant	6	4	2

4. DIAGNOSIS—PATIENTS ON ORTHOPAEDIC UNIT.

	Total	Men	Women
Head injuries	4	1	3
Fracture :—Ribs	1	1	–
Clavicle	1	1	–
Arm	2	–	2
Pelvis	2	1	1
Femur	18	6	12
Lower leg	6	–	6
Dislocated shoulder	2	–	2
Multiple injuries	4	1	3
Medical condition in addition ...	3	1	2

CAUSE.

	Total	Men	Women
Fall	21	6	15
Road Accident	6	2	4
Not known	2	1	1

5. METHOD OF ENTRY.

	Casualty	G.P. Arranged	Out-Patient	Waiting List	Other
Medical Unit ...	13	18	1	–	–
Orthopaedic Unit	27	1	–	–	1
Totals ...	40	19	1	–	1

6. DISTRICT.

	S.E.1 S.E.17	Elsewhere
Medical Unit	16	16
Orthopaedic Unit	25	4
Totals	41	20

7. SOCIAL INVESTIGATION OF PATIENTS.

	Total	Assessment Only	Not seen	Social Work Help
Medical Unit ...	32	7	9	16
Orthopaedic Unit ...	29	6	7	15
Control ...	26	–	24	2

8. SOCIAL WORK HELP.

	With Patient	With Relatives	Patient and Relatives
Practical	12	1	3
Supportive	14	5	4

Note:—There is duplication in these figures as in some cases both practical and supportive help were given.

Practical help involves the suggestion by the social worker of a service, e.g., Home Help, Meals on Wheels and, if the patient wishes it, these are arranged.

Supportive help—this involves giving a clearer understanding of the current situation through discussion with the patients or their relatives, identifying possible problems and by acknowledging individual difficulties, enabling a satisfactory adjustment to be made.

9. PERCENTAGE OF ADMISSIONS AND LENGTH OF STAY (average).

	% of admissions over 65	Average length of stay Men	Women
Medical Unit 11.1.65 to 2.4.65	15%	21.0	19.0
H.I.P.E.* 1960 General Medicine—over 65	33%	26.3	32.3
Orthopaedic Unit 11.1.65 to 2.4.65	19%	12.5	24.5
H.I.P.E.* Traumatic and Orthopaedic—over 65 Survey	18%	26.0	32.3

***Footnote.**—For interest, relevant figures from the Hospital In-Patient Inquiry for 1960 are given. As our own numbers are small their statistical validity is questionable.

10. ALTERATION IN SOCIAL CIRCUMSTANCES AS A RESULT OF HOSPITAL ADMISSION.

	Alteration	None	Died
Medical Unit	3	21	8
Orthopaedic Unit	4	19	4

11. COMMUNITY RESOURCES USED BY PATIENTS.

	Before Admission	After Discharge
Medical Unit	7	10
Orthopaedic Unit	2	6
Totals	9	16

CORRESPONDENCE

Listerism at Guy's

SIR,—In this Lister centenary year, Guy's may remember with pride that through one of her surgeons, Listerism was introduced to London. H. G. Howse on his election to the staff in 1870 visited Lister then in Edinburgh; realising the vital importance of the anti-septic technique, Howse on his return instituted it in his "septic" wards and was soon able to report, with his colleague Davies-Colley, better operative results than were obtained in the "clean" wards. Howse, later Sir Henry and P.R.C.S., used the carbolic spray and continued to do so till his retirement in 1902: the duty of directing the spray on to the operation area lay with his ward clerks: I was privileged to be one of his last firm.

Another link with Lister was forged by H. C. Cameron since his father, Sir Hector Cameron, had been Lister's first Assistant in Glasgow; our Cameron thus knew Lister and indeed visited Lord Lister when he lived in Park Crescent.

Yours, etc.,

W. M. MOLLISON.

Picket Hill,
Ringwood,
Hants.

Cosmo and Mabel Bonsor Scholarship

SIR,—It is with pleasure that I write to advise *Gazette* readers who are also members of the Guy's Hospital Past and Present Nurses' League that a sum of £150 will be made available within the context of this Scholarship in 1966.

Any League Member who is formulating plans for Post-Graduate Education either at home or overseas, or is intending to visit hospitals and health centres abroad, is invited to apply for this Award. Applications should be made in writing before 31st January, 1966, to:—The Matron, Guy's Hospital.

Yours sincerely,

ANNE M. JOHNSON,

Matron and Honorary Secretary of the Guy's Hospital Nurses' League.

Matron's Office,
Guy's Hospital,
London, S.E.1.

The Chronic Sick

SIR,—Passim is doing a service by reminding us of this problem which only too often we choose to forget—perhaps because we feel there is so little we can do. The problem and care, especially for the young chronic patient, is urgent and pressing and needs action now. This Department alone could supply the names of sufficient patients to fill at least one Special Unit. Geriatric care, either at home or in hospital, has long been the active concern of doctors and the Health and Welfare Authorities, and much has been achieved in providing more and better facilities for care. Even so there is still much to do.

Facilities for caring for those chronic patients between the ages of about 20 to 50 years have lagged far behind. In numbers the problem is small compared with that of the elderly patient, but the need to provide better and more suitable accommodation, both long and short stay, is no less urgent. The Cheshire Homes have pioneered in this and are doing a wonderful job, but are limited in the number of heavy nursing cases which they can take in any one home, and there is of course, always a long waiting list. Dr. Morton at Dunoran also has the welfare of the young patient very much at heart.

Many of these patients are being cared for at home by relatives supported by the Welfare Services, and where this is possible it is often the happiest arrangement, although it places a very heavy strain on the family. Some patients have no home, or relatives, to care for them in this way and need institutional care from the start. Relatives need a rest, and short stay accommodation can help to provide this, but sooner or later the time comes when more specialised care is needed and admission to a home or Medical Institution becomes inevitable. This can be a hard decision to face for both patient and relative, and to ease the transfer, accommodation needs to be as near home as possible. Relatives and friends can then visit regularly and the patient helped to keep his identity and remain in touch with his former environment and so continue to feel part of the family. This points to the need for small specialised Units, within or adjacent to a main Medical Centre where skilled medical and nursing care is available as required without "blocking a bed", and where both doctors and nurses can, as part of their training, contribute to the care of this group of patients.

In the area served by Guy's more accommodation for these patients is badly needed. St. Olaves and New Cross Hospitals have developing facilities for geriatric patients, and Dunoran at Bickley gives preference to the younger patient. There are also three Cheshire Homes and one home for incurables within reasonable reach, but they have long waiting lists. St. Christopher's Hospice, shortly to be built at Sydenham, will be an important addition to the facilities available for chronic and terminal patients, but this will not satisfy demand.

Guy's is being developed as a District Hospital to serve the needs of those people living in this area of S.E. London. May I hope that the needs of this small, but important, group of patients will not be forgotten.

Yours sincerely,

DIANA HUNTER, A.I.M.S.W.

Dept. Med. Social Work,
Guy's Hospital.

Blues Dinner

SIR,—A Blues Dinner has been arranged for Thursday, December 9th, 1965, at the National Liberal Club. In order that the evening will be a memorable one, it is hoped that all Full and Half-Blues currently connected with the Hospital will endeavour to attend.

W. W. DAVIES,
Hon. Sec. of the Blues Committee.

East Wing,
Guy's Hospital.

THE NURSES' PRIZE GIVING

The annual presentation of prizes and medals took place on Wednesday, 29th September, in the Physiology Theatre, kindly lent by Professor Hunt. Mr. A. E. Orchard-Lisle, Vice-Chairman of the Board of Governors, presided, and gave a short address of welcome. Charge Nurse E. Malpas presented a copy of Mr. Guy's Hospital to Mrs. Mary Stocks, B.Sc., L.L.D., Litt.D., who later presented the prizes and medals.

The Matron opened her report with an address of welcome to the guests, and expressed the regret of the Nursing Staff concerning the absence of Lord Robens: stressing how delighted they were to welcome him as the Chairman of the Board of Governors. This was followed with an interesting account of the changes of the past year—the most notable of these being the establishment of the Preliminary Training School at Guy's after a period of nineteen years at Holmesdale. The Matron then referred to plans for the year ahead: the launching of the 1962 experimental syllabus of the General Nursing Council: a new plan of training for Guy's student nurses: a revision of the present pattern of the patient's day: the implementation of shift rotas of duty for nursing staff: and—the launching of an extensive scheme of upgrading of accommodation in the Nurses' Homes.

The Matron then emphasized the need for post graduate education in Nursing affairs, and reported that in 1965, from a total of 108 Sisters at Guy's, 36 had attended conferences and courses in Great Britain and abroad. Looking into the future, the Matron reminded her audience that the formulation of plans could be tedious: the introduction of plans was always challenging: but that the consolidation of new plans placed the greatest demands of all: adding that it was this phase upon which the nursing staff would now embark together—and without falter.

The Matron reminded the nurses that to-day, when every project appeared to require excessive expenditure, they should guard very closely the priorities for which all must aim. "Build we must—build with bricks, and mortar, with towers of concrete, with syllabuses, and with plans—with finance and statistics—but, although these are, of course, items of supreme importance, it is building with people that is second to absolutely nothing at all." The Matron warned the nurses to resist all pressure which might obscure the needs of the patient, reminding them that they belonged above all to the patient, and were also "Guy's Nurses and Guy's Ambassadors always".

In conclusion, the Matron reminded the nurses that the year of 1965 had brought with it several anniversaries of fairly recent history. "May I remind you that were it not for you the sacrifices of yesterday would have been in vain: you are the living triumph of those disasters: you are the generation for whom the Battle of Britain was fought: you are the living bricks upon which the future of the profession, and indeed of the nation, will be built: the bridge which must carry the glory of yesterday into the living reality of to-morrow."

Reports on various aspects of nurse training were given by Miss B. B. Whyte, Principal Nurse Tutor; Miss M. E. Laws, Theatre Superintendent, and Miss L. Weir, Acting Lady Superintendent of Guy's Evelina Hospital.

Mrs. Stocks then presented the prizes and medals. The Sarah Mills Award for distinguished and outstanding service to the Hospital went to Miss A. Falwasser, M.B.E., former Sister of Job Ward.

Mrs. Stocks, well-known radio personality, gave an interesting and provocative address. She said that she felt at home in the assembly, having been brought up in a medical and nursing family. Mrs. Stocks made comparisons between Nursing and other professions. The advantages of being a member of the nursing profession were that nurses had prestige and, when qualified, they had the world at their feet. They could go anywhere in the world and, because of their value, even in troubled areas, their safety was assured. Nursing was never monotonous and there was a choice in the various branches.

Mrs. Stocks pointed out that marriage and nursing could be combined successfully; she urged the nurses to keep alert minds and to take a greater interest in public affairs. She thought that more nurses should take an active part in the administration of the country.

Mrs. Stocks concluded her address by saying that the disadvantage of some professions is that there are times when one has a black moment of depression and says, "would everybody be just as well off if I was not doing what I am doing?" Nurses should never suffer from this dark period.

Following the ceremony, tea was served in the Nurses' Home.

MEDALS AND PRIZES FOR THE YEAR 1964 - 65

THE GOVERNORS' PRIZE.		**Examination in Pharmacology**
1st Prize	January 1965	Nurse Anthea Gordon
	April 1965	Nurse Hilary Spring
	July 1965	Nurse Carolyn Macpherson
2nd Prize	January 1965	Nurse Elizabeth Hind
	April 1965	Nurse Catherine Lambert Nurse Kilanti Wimalakirti
	July 1965	Nurse Joan Pinsent
THE KEOGH PRIZE.		**First Year Patient Studies.**
1st Prize	October 1963 Set	Nurse Susan Baldwin Nurse Catherine Mercer
	January 1964 Set	Nurse Anthea Gordon
	March 1964 Set	Nurse Sarah Platt
	June 1964 Set	Nurse Isobel Winslade
2nd Prize	January 1964 Set	Nurse Elizabeth Hind
	March 1964 Set	Nurse Margaret Chase Nurse Kilanti Wimalakirti
	June 1964 Set	Nurse Maureen Taylor

THE GOVERNORS' PRIZE.		**Second Year Patient Studies.**
1st Prize	October 1962 Set	Nurse Elizabeth Lampitt Nurse Patricia M'Caw
	January 1963 Set	Nurse Brenda Slade
	March 1963 Set	Nurse Geraldine Bowers Nurse Joan Hetherington
	June 1963 Set	Nurse Anne-Maria Clarke-Halifax Nurse Yvonne Reffell
2nd Prize	January 1963 Set	Nurse Dorothy Chapman
THE GOVERNORS' PRIZE.		**Guy's Final Patient Studies.**
1st Prize	October 1961 Set	Nurse Anne Seymour
	January 1962 Set	Nurse Carolyn Clark
	March 1962 Set	Nurse Judith Marshall Nurse Gudrun Treutler
	June 1962 Set	Nurse Ann Featherstone Nurse Corinne Heyworth
2nd Prize	October 1961 Set	Nurse Margaret Brotherhood
	January 1962 Set	Nurse Rosalind Bucknall
THE BERNARD LOFTUS BROWN PRIZE.		**Guy's Final Examination.**
1st Prize	July,1964	Nurse Susan Kell
	August, 1964	Nurse Deirdre Kemble
	November 1964	Nurse Iris Warburton
	February 1965	Nurse Valerie Joynes. Nurse Elizabeth Malpas
THE MORRISON PRIZE.		**Guy's Final Examination.**
2nd Prize	July 1964	Nurse Jane Maxted Nurse Caroline Turner
	August, 1964	Nurse Barbara Jones Nurse Suzanne Taylor
	November 1964	Nurse Jane Darke

EVELINA CHILDREN'S HOSPITAL OF GUY'S HOSPITAL SCHOOL OF NURSING

MEDICAL COMMITTEE PRIZES.	**Awarded to the Nurses gaining the highest marks in the examination in:—**
HOSPITAL FINAL EXAMINATION (Practical).	
1st Prize	Nurse Petronella MacMaster
HOSPITAL FINAL EXAMINATION Post-Registration Course.	
1st Prize	Nurse Gillian Ratcliff (née Harvey)

THE JEAN MORTON AWARD.

Awarded to the Nurse obtaining the highest marks in the Practical part of the Guy's Final Examination, and taking into account her ward reports, her general influence within the Training School, her powers of leadership and her interest in the activities of the Profession :

Nurse Isabel Manwaring

THE EMILY MACMANUS PRIZE.

Awarded to the Nurse obtaining the second highest marks in the Practical part of the Guy's Final Examination, and taking into account her ward reports, her general influence within the Training School, her powers of leadership and her interest in the activities of the Profession :

Nurse Iris Warburton.

THE SARAH MILLS AWARD. Miss Angela Falwasser, M.B.E.

CAZENOVE MEDALS.

Awarded to the Nurses obtaining the highest aggregate number of marks in all examinations and taking into account their record of practical work and their influence within the Training School :

Cazenove Gold Medal. Nurse Deirdre Kemble (née Latta)
Cazenove Silver Medal. Nurse Elizabeth Malpas
Cazenove Bronze Medal. Nurse Suzanne Taylor

BUTTERWORTH MEDALS.

Awarded to Guy's trainees and trainees of the Evelina Hospital for a minimum of 7 years' consecutive service:—

Miss Mavis Fabling
Miss Pamela Hunt
Miss Doreen Marsh
Miss Jeanne Mitchener
Miss Eileen Quealy
Miss Patricia Wardrop.

ANNE M. JOHNSON,
Matron.

NEUROTICS

by

G. L. DAVIES

"It is among those who belong to the magnificent, the lamentable, family of neurotics that we find the salt of the earth. They it is, and not others, who have founded religions and achieved masterpieces. The world will never know how much it owes to them, nor yet what they have suffered in the act of giving."

(Proust: *A la recherche du temps perdu*)

In my day at Guy's, some forty years ago, the word "neurotic" was a word of scarcely-veiled contempt for those people, some of whose complaints were very imperfectly, if at all, understood. The student took his cue from the houseman, and members of the senior staff no doubt rode off at times on that very unsatisfactory diagnosis with which they were, no doubt, themselves often deeply dissatisfied. Poverty and squalor, such as existed in the Borough, must have been a fertile breeding-ground for neuroses of all kinds. Having myself, before becoming a medical student, worked amongst all kinds of such squalor and poverty in the slums of Hoxton and Bethnal Green, this light-hearted fobbing-off as neuroses by immature and inexperienced young men what must have been real suffering, was something that was often very distasteful, and lacking in conviction, even to my then medically-untutored mind. This is not to say that real neuroses did not exist, and had existed, for aeons of time and tend to grow with the growth of civilisation.

The strange thing about the propensity towards neurosis is that it seems to favour the two extremes of society, (1) the educated, and even intellectual class, who know so much and yet do not know sufficient to recognise what is wrong with themselves; (2) the poor and ignorant who know little and always fear the worst. ("*Omne ignotum pro magnifico est*", as Tacitus wisely remarked.)

The neurotic is gifted (or cursed) with a sensitivity of perception denied to the ordinary run of people. He sees things often to his own disadvantage, and in his own person, which others cannot see, and he suffers accordingly. As has been said before, he is often a person of high intellect, Proust for instance, or a Dr. Johnson tapping his way over the pavements, counting the flagstones and touching the lamp posts, and returning to repeat the process if he thinks he has missed one (*itque reditque viam totiens* as the old Latin grammar used to say in another connection). He might be the senior physician of a Hospital awaiting his bout of asthma as he goes over Salisbury Plain, merely because (as he told us) it was there that he had his first attack. What, too, is one to think of that Napoleon of the Press, the

late Lord Northcliffe, "who sent a letter or a cable to his mother each day, who was a hypochondriac, and eventually mad, who made £200,000 a year in ten years from nothing, and thought money was important only when you were ill or travelling". If great wits are allied to madness, then Northcliffe was surely one of those. As much so was Dean Swift who, under the guise of writing stories for children, e.g., *Gulliver's Travels,* produced revolting satires. The question in this case, as indeed in other cases of neuroses, is how much more was Swift a psychopath than a psychoneurotic. "Swift is both a glory and a disgrace of world-literature. In his books, in his life, he exposes to the mind's eye the lowest depths, and the loftiest heights of which the mutable spirit of man is capable. In him Reason, as the 18th century understood it, committed suicide." [Drinkwater.]

It would not be unfair to say that all addicts to some particular vice are neurotics because they are quite incapable of breaking themselves free from their particular vice. If the absinthe of Van Gogh, the opium of Coleridge and De Quincey and the homosexuality of a Proust or an Oscar Wilde were evidence of neurotic personalities, so too are the cigarettes of the chain smoker. And if, often beneath an appearance of mental vacuity, such smokers claim that their cigarettes are an aid to mental concentration, they should know by now that they are also conducive to a distressing form of death which the General Practitioner can only too well verify, for it sometimes falls to his lot to contemplate the final stages of this particular form of self-annihilation.

It has been said that everyone is neurotic in some way or another: "All the world's queer except thee and me, and even thee's a little queer," as the old Scot said to his wife. However, it will not do to associate neurosis too closely with psychosis, for many neurotics are well aware of their neuroses which they cannot shake off because, with time, whatever form it has assumed, it gets so firmly embedded that it becomes a conditioned reflex.

Merely because we don't understand these people we have no right to dismiss them with a shrug of contempt. A disorder of function, such as neurosis is, could well have as its cause some underlying somatic disorder, some inborn error, for instance, of the autonomic nervous system which, as yet, has not sufficiently interested the research worker. A search for the sub-conscious factor underlying a particular neurosis might reveal its starting point, but there seems to be no answer to the question why, for instance, if two children are exposed to the same malign circumstances, the one should, as a result of it, be afflicted, possibly for the rest of his life, with some form of neurosis, whilst the other may show no trace of any ill effects. One might as well ask why two people exposed to the same infections do not of necessity both get them. We say glibly that one must have some natural immunity, pre-supposing the presence of circulating antibodies. We are, however, not so ready to explain why two people, both possessed of the same (macroscopically) nervous systems, do not

develop neurosis in the same given circumstances. And this is where the facile diagnosis of neurosis fails. Proust recognised this fact. Writing to his mother he says: "Worries like mine, and even worse than mine, much worse, do not necessarily produce in everyone the same degree of suffering. You have got to consider two entirely different things, the material *fact* which is the cause of the suffering, and the individual *capacity* for suffering which depends upon his temperament." Here we are again up against the word "temperament" for which particular quality in a given individual one would like to contend that there must be some somatic cause. All this, no doubt, is linked up with the study of genetics, a subject of which a lady specialist in the subject stated a week or two ago in the B.M.J. that the General Practitioner is in complete ignorance. No doubt. One pictures some such General Practitioner (myself for instance) seated in front of a garrulous old lady prating about all kinds of unrelated symptoms and wondering vaguely what the state of her chromosomes might be, a speculation which could well provide the answer to a particular neurosis if the answer were only known. Conceivably, neurosis might be due to some lack or excess of an internal secretion, though the actions of those are now fairly well known. In the current number of the B.M.J. (18.9.65), Sir Charles Symons speaks of a case of abrupt loss of vision, at first ascribed to hysteria, which was later found to be due to a simultaneous infarction of the visual cortex in both occipital lobes. In the same journal one reads of people who are eventually found to be suffering from diabetes, but who were first diagnosed as psychoneurotics because they had, before their diabetes became manifest, an abnormal urge to eat chocolate. Cases such as these only go to show on what a tenuous foundation the diagnosis of neurosis frequently rests. It does not need much imagination to think of the possible tragedies which can follow upon a mistaken diagnosis of neurosis; a loss of interest perhaps on the part of her attendants, delay, a transfer perhaps to some quiet ward occupied by the really intractable; during which time organic signs and symptoms may develop apace. How much better, perhaps, instead of using the word "neurosis", to be honest and say "cause unknown", and keep them in mind for further reviews if necessary, *sine die*, as the lawyers say.

NOTICES

Psychological Society

On Monday, November 1st, at 5.30 p.m., Dr. David Stafford-Clark, having accepted the Presidency of the Society, addressed a large audience on the subject "What is Psychology?" There were about 200 students present. These numbers acknowledged the popularity of the choice of speaker. It also, we hope, represented a healthy interest in the subject and in the Society. This was in some ways an historic occasion. For several years we have watched the death-throes of societies at this Hospital, in an orderly progression to nonentity. Here, for the first time in a very long while, we witnessed the *birth* of a society.

Psychology is a term seldom defined, although used in the everyday conversation of many people. It has been sarcastically called "the science that tells you what you already know in terms you can't understand." Dr. Stafford-Clark defined it as "*the scientific study of behaviour and experience in living creatures.*" He discussed the two main kinds of psychological method—the entirely objective/or behavioural, and the subjective; as exemplified by the work of Watson and Freud respectively.

The Psychological Society was formed at a meeting on October 18th, when the following committee was elected:—Chairman, Michael Simpson; Secretary, Graham Pay; Publicity Secretary, Richard Forrest. Committee members: R. D. Spicer, W. T. C. Hughes, P. D. Warren, R. Cowan, R. H. Savage, M. D'Souza.

The Society will meet every two weeks; at alternate meetings, student papers will be presented. Other meetings will consist of guest speakers, practicals, demonstrations, etc. Student papers will be presented to the Committee in writing, prior to being read to the Society. At the end of each year the papers read before the Society will be placed before judges, chosen by the committee, who will award a prize to the best paper.

M. A. SIMPSON.

Catholic Society

A Brains Trust will be held on Thursday, the 17th November, at 8 p.m., in the North Common Room of the Students' Club. Professor D. J. Anderson will be in the chair. The panel will consist of a doctor, a civil servant, and a member of the Catholic Chaplaincy.

All members of the Hospital are welcome to attend.

Guy's Hospital Church of England Society

The first meeting of the Society this year will be on Wednesday, November 24th, at 1.05 p.m., in the Chaplain's office. The subject under discussion will be "The Church in the University." Anyone who wishes to be shown the way to the Chaplain's office should be in the Hospital Chapel at 1.05 p.m., on Wednesday. A light lunch will be available.

The Pupils' Physical Society

The Pupils' Physical Society began their new session with a look at one of the more controversial aspects of " fringe medicine". They invited Mr. Gerald Lever to talk on " Acupuncture " on Monday, 11th October. The meeting was well attended and taken in a commendably dispassionate spirit.

He discussed briefly the origin of acupuncture in the Taoist philosophy. He described the twelve "vital" organs and their corresponding meridians and he indicated how the two radial pulses in fact contained twelve pulses (palpable to the trained observer), each indicating the state of one of the vital organs.

His "cures" included relief from headache, back pains and even symptoms such as insomnia, which he did not know he was treating. It was reassuring to know that he did not hold out any hopes of cure for patients with such serious conditions as cancer and disseminated sclerosis.

Afterwards the audience did not ask Mr. Lever to explain his art in mechanistic terms, but restricted their questions to the common ground of his own empiricism—" Did lumbar puncture, for instance, ' acupuncture ' the patient's ' line of conception.' "? The President, Mr. M. D'Souza, thanked Mr. Lever for coming and Dr. Kendall for kindly chairing the meeting. He reflected accurately the feelings of those present when he said: "I came a sceptic, I remain a sceptic, but at least now I am a more informed sceptic."

MARCUS PEMBREY.

Dental Society

A meeting was held in the Dental Theatre on November 4th to discuss the points arising from publication of the report of the Dental Education Committee. Although many members of staff attended, the response of the students was poor, and regrettably no representative from the house-surgeons was present.

The report consisted of three parts:—

(1) The views of the Department Heads on present arrangements and future plans.
(2) The findings of a questionnaire conducted among 230 Guy's students—126 questionnaires were returned.
(3) A report of informal discussions with students from the other London dental schools.

It was pointed out that a copy of the New Curriculum has been on view in the Dental School for several weeks. Questions put by the committee to Mr. Warne and their answers have been circulated among students, too.

It was felt that the major points concerned:—

(1) The purchase and maintenance of instruments by the student.
(2) The rôle of house-surgeons in the supervision of students.
(3) The efficacy of lectures as opposed to tutorials.
(4) The requirements of the Prosthetic Department.
(5) The setting up of a student committee to continually review dental education.
(6) The problem of rotating dresserships in specialist teaching within dentistry.

Mr. Wilton reporting on staff opinion said that more staff and better facilities for staff and students were envisaged as soon as possible, and that much thought had been given to the general and special education of the student. All departments hoped to increase the amount of teaching, and technical work by the student will be reduced.

Mr. Peter reported on the findings of the questionnaire that:—

(1) Full and part-time staff were both necessary 85%
(2) That the ratio of staff to students is at present unsatisfactory .. 79%
(3) That students are not happy with the amount of supervision house-surgeons now have 62%
(4) Tutorials were favoured rather than lectures, and lectures are preferred in the morning 72%

(5) Present arrangements concerning instruments are unsatisfactory .. 92%
(6) That prior to an examination, present arrangements do not give enough time for revision 94%
(7) That the present points system is unsatisfactory 62%
(8) That the present system for working on Saturday mornings is not satisfactory 88%
(9) That more technical work should be done for the student in Prosthetics 75%
(10) The concept of the general treatment of patients is well received.. 96%
(11) That a department of diagnosis and treatment planning is essential in the new curriculum 78%
(12) That there be a standing committee of staff and students to review dental education 97%

A vote was taken at the meeting, which showed that about 50% of the students present had reservations concerning the introduction of the New Curriculum under present circumstances, although they approved its main concepts. Mr. Riley reported the views of other hospitals. He said that most schools were working towards a lower ratio of staff to student. Only at Guy's do house-surgeons supervise students. That where educational committees are present, they are invaluable. That at one school there is now no points schedule for prosthetics or conversation, and finally that where central sterilisation and services departments have been introduced, they have been well received by the students. Dr. Cawson, the chairman, then invited questions and pointed out that our present predicament is lack of space and of staff, and thus of facilities if further staff were recruited.

The rôle of dental education in producing a skilful technician or a university graduate was debated with vigour. The meeting seemed to favour the latter view. It was pointed out that although dental instruments might cost £150, one received some £60 from County and School, and the value of instruments after use might still be £50 to £70, hence undergraduates were not financially embarrassed in the long term. It was suggested that supervision by house-surgeons helped in their education perhaps to the detriment of that of the student. A definition of tutorial was demanded and given as " a discussion between a tutor and 5—7 undergraduates, about a topic which had been precirculated and where relevant references had been given." The importance of the contribution of the student to the tutorial was emphasised.

Dr. Cawson concluded the meeting by saying that it was a further peg upon which thoughts could be hung. A staff-student committee on education was a necessity, and that he hoped that progress would be made in dentistry, albeit slowly.

PETER SIMS

REVIEW

A POCKET GYNAECOLOGY.

S. G. Clayton. Published by Churchill. 5th Edition. 122 pages.

This little book is firmly placed as the gynaecology revision textbook, it is concise, complete, up-to-date and well presented. It deals with the anatomy embryology and physiology of the subject and goes on to the diseases of the organs involved. It has a logical and easily memorised format with an economy of words without omission of subjects of import. It can be read and re-read until its matter has been completely assimilated. At the end is an excellent synopsis of the principles of operative in gynaecology. One criticism, the section on dysfunctional uterine bleeding is not as clear as it could be. However, this book is commended to those revising for finals since it will succeed in giving the student confidence to carry him through his short "face to face" with the examiners.

P. BOWDEN.

SPORT

SPORTS DIARY

Nov. 12, 13, 14—Squash Tour to Sussex.
„ 13.—Rugby Football versus Old Alleynians at H.O.P.
Association Football versus Royal Dental Hospital. Away.
Hockey versus Gravesend at H.O.P.
„ 16.—Squash versus British Petroleum. At Home.
„ 17.—Association Football versus U.C.H. Away.
„ 20.—Rugby Football versus Metropolitan Police at Imber Court.
Association Football—Past versus Present H.O.P.
Hockey versus Surbiton II. Away.
Squash versus R.A.F., Cranwell. At Home.
„ 23.—Squash versus Ebbisham S.R.C. At Home.
„ 25.—Squash versus Escarts S.R.C. At Home.

RUGBY FOOTBALL

Guy's have not lost in three games during the past fortnight, though the matches have been against weaker opposition than the earlier matches. In the first game we beat Cambridge 18—3. For the past three years we have played them on a Wednesday evening and have not beaten them before, but this time we beat them convincingly.

We normally reckon to put twenty points on London University, and to lose to them would be unthinkable. This year we could manage only a draw 3—3. However, the University are a much improved side, and only three days after Guy's had played them, the University soundly beat the London Hospital 11—0, last year's winners of the Hospital's Cup. Last Saturday we beat Old Blues 11—0.

At the moment, Guy's are well represented in County Rugby. Four players are playing for County first teams and many others have had trials. Cockburn and Ross have been picked for Kent, and Edgar recently scored two tries for Eastern Counties against Surrey. C. Thorburn, an Oxford Blue, who has recently come to Guy's is playing for Middlesex, and we congratulate him on being selected to play in a Scottish trial for exiles in London.

ATHLETICS

The University of London Winter Relays and Field Events Championships are at Motspur Park on Wednesday, 17th November.

REPORTS & RESULTS

RUGBY FOOTBALL

GUY'S v. CAMBRIDGE

At Cambridge. 30th October, 1965.
Result: won 18—3

Guy's went up to Cambridge, a club partially revived by Dickie Jeeps four years ago, looking for the first win in four games.

It was a very cold day, and Guy's played the first half into the teeth of a force 8 gale. These conditions made handling exceedingly difficult, and the Guy's back-row made good use of dropped passes when Cambridge should have been using the wind to their advantage. In fact, Cambridge were held until the final minutes of the half, when the burst through the back of the line-out on a ball that had been tapped back and scored.

The wind had dropped considerably by this time and this was probably an advantage for Guy's as handling became easier. Guy's were soon off the mark when centre Edgar broke inside to score near the posts. The score was increased when Ross, after several good runs down the wing, beat his man and scored in the corner. Further tries came from scrum-half, Swift, and centre, Beecham. Three tries were converted by Elliot.

We were superior to Cambridge in every aspect of the game and beat them soundly.

Team: D. Elliot; I. Ross, R. Beecham, A. Edgar; P. Bundred, B. Rowlands; P. Swift, J. Davies, C. Lewis, R. Stansfield, A. Kingdon, M. Cockburn, H. Sharp, C. Thorburn, P. Williams

HOCKEY

GUY'S v. KINGSTON GRAMMAR SCHOOL

At H.O.P. Saturday, 30th October.

Result: lost 1—3

On a bleak afternoon the XI suffered their first defeat of the season from a well-balanced and closely-knit team of schoolboys. It was an afternoon of disappointments; the change in the weather and the failure of a Southern Counties Umpire to arrive doing little to enhance the enjoyment of the game.

At first Guy's attacked strongly, if ineffectively, but it was the opposition who opened the scoring. A firmly hit centre from the right-wing; a mistake by the goalkeeper; and an opposing forward had plenty of time to place the ball in the net.

The K.G.S. goalkeeper was then given plenty of opportunities to prove his worth, but finally Appleby gave him no chance with a firm shot a few seconds before half-time. After the interval, Guy's failed to sieze the initiative and conceded two more goals, due to the systematic splitting of their defence by accurate through passes, some indifferent tackling and a certain lack of urgency throughout the team. A rather disappointing performance after the team's earlier successes.

STEPHEN REAR

GUY'S v. IMPERIAL COLLEGE

Away. Saturday, 6th November.

Result: drew 2—2

This game was played on a hard, dry pitch which made ball control very difficult. However, this was no excuse for an indifferent display by the Guy's team, who escaped with a lucky 2—2 draw. The main general criticism was a failure to look before passing; as a result, Guy's produced very few co-ordinated movements.

Guy's started off reasonably well, and played some good hockey in the first ten minutes, though the opposition goal was only seriously threatened once. Gradually, I.C., playing the more thoughtful and controlled hockey, took command, and with better finishing might well have had more than the two goals they scored early on in the second half. With a quarter of an hour left, Guy's, for once, made good use of a short corner, Caruthers turning in Bennett's shot which had been blocked. Soon afterwards, during a goalmouth scramble, the scores were levelled, Appleby pushing the ball home.

Both sides came close to scoring the winner in the last ten minutes. Justice would not have been done had Guy's snatched that goal.

Team: S. Rear; M. Horrocks, R. Kendrick; J. Crafts, N. Turfitt, P. Rushmer; R. Caruthers, S. Cripps, M. Appleby, P. Bennett, C. Pearson.

M. APPLEBY

SQUASH

A very good start has been made to the season with all Cumberland Cup matches won so far. Considerable enthusiasm has been shown in the Club, and a "ladder" is attempting to sort out the mass of talent. We look forward to continuing success during the rest of the season.

Results:

v. Baltic Exchange. Lost 2—3.
v. Beaumont Union. Won 3—2.
v. Imperial College. Lost 2—3.
Cumberland Cup v. Lensburg. Won 4—1.
v. D. Johnians. Won 3—2.
Cumberland Cup v. West London Sq. C. Won 3—2.
Cumberland Cup v. Bart's. Won 4—1.
Cumberland Cup Team: ,
J. H. Newman, J. R. Webb, E. P. Davis, C. L. Newman, N. M. White.

FENCING CLUB

As is amply demonstrated by the excellent results, although not strong in membership, the fencing club is strong in spirit and high endeavour.

Colin Durant and Lawrence Cree maintained a good standard throughout the season. Roland Knight's somewhat unorthodox approach proved highly effective, and Stewart Bramwell and Bob Jones were always reliable.

There were 16 fixtures, with only two defeats. The Club regained the Inter-Hospitals Cup, and was narrowly beaten by Salle Boston in the London League.

The Club has had its first match of this season against Imperial College.

Result: Guy's won 10—16.
Knight, 4; Bramwell, 2; Durant, 2; Cree, 2.

CROSS-COUNTRY

After an encouraging start, we have continued to do reasonably well and produce a good turn-out despite losing people, both due to injury and on the course! The first team is ninth in the first division of the London Colleges League (out of fourteen). The second team is well up in the second division. P. Witting and Brian Smith represented the University against Cambridge last Saturday, and Guy's is swelling the ranks of United Hospitals.

Results: 1st league race. 2nd October.

Parliament Hill Fields.

17.—P. Witting.
49.—B. Smith.
74.—G. Waterhouse.
80.—J. Wheeler.
81.—D. Halestrap.
98.—P. Vernon
108.—E. Bowen-Jones.
140.—W. Smith.
155.—T. Kirk.

1st team 8th

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the following appointments in the Dental Department for Children, to commence duties on the 1st January, 1966:

Registrar, with attendance on six sessions per week;

Orthodontic Assistant (Registrar grade) with attendance on six sessions per week.

(These two appointments may be linked to make one full-time appointment.)

Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, London, S.E.1, not later than **Wednesday, 1st December, 1965.**

PASS LIST

UNIVERSITY OF LONDON
Ph.D.

C. J. Garratt

D.C.P.

J. P. Lee-Potter — I. I. Zayid

ROYAL COLLEGE OF SURGEONS OF EDINBURGH
Fellowship

M. F. Terry

PRIZE LIST

DENTAL SCHOOL
PRIZE EXAMINATIONS, 1965

The following awards have been made:—

SECOND YEAR PRIZE EXAMINATION
JULY, 1965
First Prize — A. K. Cornell
Second Prize — M. J. O'Grady

FINAL YEAR PRIZE
SEPTEMBER, 1965
First Prize — J. V. Holland
Second Prize — T. J. Storrs

JACK WHEATLEY MEMORIAL PRIZE
OCTOBER, 1965
Prize — T. W. Negus

CARLETON HUNTER MEMORIAL PRIZE
OCTOBER, 1965
Prize — A. Winskill

The Leslie Hillman Prize for Haematology
Equal 1st,
R. A. C. Hughes and M. E. Pembrey

BIRTHS

ROBERTS.—On September 30th, 1965, to Patricia (née Gamble) B.D.S., and John Roberts, a daughter, Emma Catherine, a sister for Hugh and Paul.

ESSON.—On 21st October, 1965, to Elizabeth (née Storrs Fox), S.R.N., S.C.M., and Dr. Walter Esson, of 16, Neston Way, Handforth, Cheshire, a daughter, Fiona Elizabeth Storrs.

HUMPHREY.—On 7th October, in St. Mary's Hospital, W.2, to Delyth (née Davies) S.R.N., and Dennis C. Humphrey, F.R.C.S., M.R.C.O.G., a son, Richard Charles, a brother for Susan and Angela.

KNOTT.—On October 15th, to Captain Nigel Knott, B.D.S., L.D.S., R.A.D.C., and *Rosemary (née Hepworth)* S.R.N., a son, Andrew James.

RAWLINS.—To Josephine (née Heylen, M.B., B.S.) and Frank Rawlins, on the 14th October, 1965, a daughter, Helen, a sister for Brigitte and Frank.

WILLE.—On 30th October, 1965, to Mair and Richard Wille, of 138, Brooklands Drive, Leighton Buzzard, a daughter, Sian Catrin, a sister for David.

Birth, Marriage, Death, and Change of Address notices are without charge to subscribers. For Personal notices the charge is £1 1s. 0d. for 15 words, additional five words 10s. 6d., minimum 15 words. Non-subscribers will pay £1 1s. 0d. for all notices other than Personal which will be charged at the above rate.

ENGAGEMENT

From Toronto, where the wedding will take place shortly, the engagement is announced between Dr. Nicholas F. Forbath, M.A., M.D., F.R.C.P.(C), son of Mrs. Forbath, of Toronto, and Dr. Anne B. Kenshole, M.B., B.S., D.R.C.O.G., daughter of Mr. H. H. Kenshole, D.S.O., T.D., and Mrs. Kenshole, of Chigwell, Essex.

DEATH

QUICK.—On October 29th, 1965, suddenly in hospital, *Leonard Albert Groves Quick*, L.D.S., R.C.S., of Heathside, Hillcrest Road, Dartford, dearly beloved husband of Joan, and father of Clive, Julie, Diana and Richard.

CHANGES OF ADDRESS

FRANCE.—R. D. France, M.B., B.Chir., to 25, West Street, Godmanchester, Hunts.

HOWARD.—Dr. M. A. Howard, to Low Cedars, Westerland, Paignton, Devon.

TREADGOLD.—Miss Sylvia Treadgold, to 24, Oaklands Park, Bishop's Stortford, Herts. Telephone No. Bishops Stortford 2072.

Peter and Susan Eden, 28, College Street, Irthlingborough, Northants. Tel. Irthlingborough 387.

EDITORS A. E. RAYNES and M. F. D'SOUZA
SPORTS CORRESPONDENT A. PROCTER
FORTNIGHTLY TWO SHILLINGS VOLUME 79 NUMBER 2017

PASSIM

TECHNOCULTURE

The continuing need for a more satisfactory emotional relationship with the Machine Age was well expressed by Dr. H. M. Dowling in a recent article in *The New Scientist,* under the somewhat ungainly title of "Towards a Technoculture". In the beginning of this article, Dr. Dowling points out that "Modern man spends most of his time in a world of artefacts, of things designed by man and fabricated by machines . . . and that there can be no doubt that the average man comes much more into contact with these man-made phenomena in his environment than with the biological entities such as plants and animals". We are now in the process of creating what will be the "natural" surroundings for ourselves and our children and consequently the need for a responsible artistic involvement in the products of Science and Technology has never been greater.

Machines promise to relieve us of every task we do not wish to do: they have already manifest their capacity to extend our power and enrich the quality of our lives beyond the imaginations of our predecessors. Equally apparent, however, has been the squalor and damage they have brought in their wake and it is these latter effects that have marred our emotional attitude towards them.

The poetry of the machine age has not yet been written and it still seems bizarre to the average individual, to talk about machines as possible objects of beauty since their various functions too often supersede all other considerations. But if, as seems inevitable, they are going to occupy an ever-increasing part of our lives, their value to us cannot be simply utilitarian and ultimately, before we can exist in real harmony with them, we must ensure their aesthetic acceptability.

This is essentially the task for the artist within the realms of science. But whereas in the past man's art strove to emulate the forms of unspoilt nature, now it must attempt the infinitely more challenging business of creating novel shapes which are no less humanly pleasing than these but capable of making our mechanised environment become both our solace and our inspiration.

The magnitude of such a task is beyond assessment and its pitfalls legion. It's guidelines, too, are scant, for the psychology of aesthetics is certainly no more than embryonic, but the price of failure is an ever-spreading Subtopia, a comf ugly mediocrity, a land of Cockayne instead of a heaven.

Transferred Transfusion

Some of the greatest achievements at Guy's in recent years have relied on the efficiency of the Blood Transfusion service. The increasing use of the by-pass machine has created a demand for large quantities of fresh blood and has made the central organisation of the transfusion unit inevitable.

The unit has recently moved into a new, spacious department built into the ground floor of New Guy's House. Here it is more suitably situated to supply casualty, the operating theatres and surgical wards. Previously, donors have been bled in Back Surgery or in the Chest Clinic, almost on any available couch, and the grouping and cross-matching have been carried out in inadequate and inconveniently situated laboratories. The new unit brings the laboratory and the donor together, and is the first of its type to be opened in a hospital in this country. It consists of a donor bleeding room, rest room, laboratories and refrigerated storage space. Its decoration, reception, smart chairs and even lighting, give the impression of an air-terminal rather than a clinic. Great attention has been paid to the comfort of the donor and the rest room is equipped with sufficient refreshment to replenish the Spit.

There are at present about four by-pass operations per week at Guy's, and in order to maintain its supply for these and the rest of the hospital's demands, Guy's receives blood from three sources, the National Blood Transfusion Service, the Red Cross, and the Guy's Panel of donors. The new unit will be open to receive donors all day and several evenings a week.

Blood donors play an invaluable part in modern treatment, and the kindness of this voluntary service should not be overlooked. It is hoped that the new unit will encourage donors, and that it will meet the increasing demands made on it by the specialized techniques which are developing at Guy's.

Lord Brock has been awarded the Lister medal for 1966. The medal was awarded for his contributions to surgery of the heart and lungs and in particular his elucidation of the broncho-pulmonary segments which inspired the segmental surgery of the lung, and to his pioneer work on the corrections of vascular derangements of the heart, and the use of hypothermia in cardiac surgery.

Lord Brock will deliver the Lister Memorial Lecture in London in April, 1967.

Dr. J. A. P. Trafford was appointed consultant physician to the Brighton and Lewes Hospital Group in August. We regret the delay in reporting this.

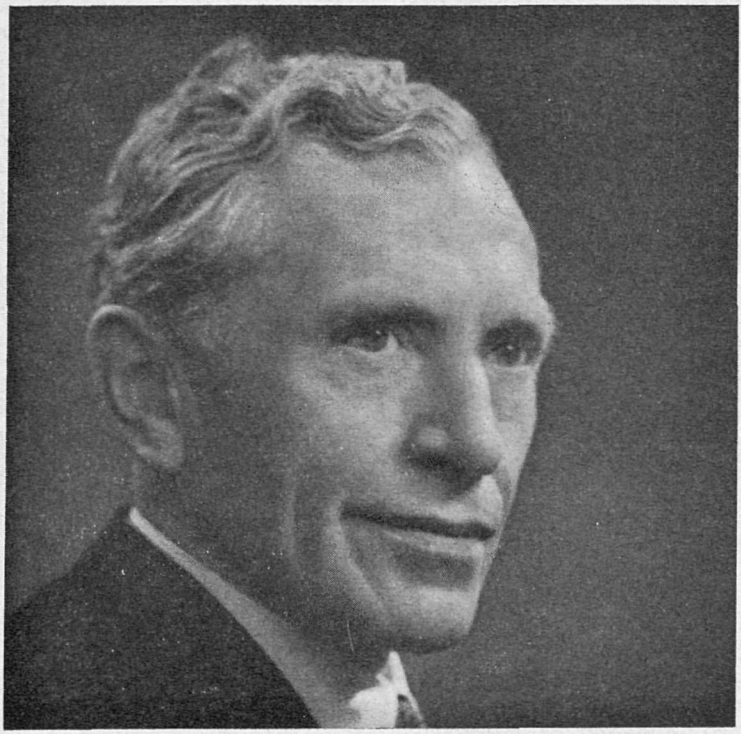
Dr. Hywel Davies has won the Carey Comb's Prize awarded by the University of Bristol. The subject of his contribution was "Dyspnoea in atrial septal defect".

GUY'S DIARY

NOVEMBER			
Exhibition.			Fractures of the Spine.
27th	S.	10.00	Clinico-Pathological Meeting will be held in the Clinical Theatre.
29th	M.	1.00	Clinical Lecture. LORD BROCK. "The Management of Pleural Infections".
29th	M.	4.30	Applied Physiology Lecture. "The Analysis of a Patient with Cardiovascular Disease". Dr. D. C. DEUCHAR.
29th	M.	5.30	Psychological Society. "Group Thinking". Speaker: Dr. ROUSE.
30th	Tu.	1.00	Clinical Lecture. Dr. MACKENZIE. " Migraine."
DECEMBER.			
2nd	Th.	1.00	Clinical Lecture. Mr. WASS. "Diarrhoea".
2nd	Th.	4.15	Physiological Society. "Pregnancy". Speaker: Mr. R. E. COWAN. Chairman—(to be arranged).
3rd	Fr.	4.15	Experimental Psychology Lecture. Mr. M. F. PIERCY, M.A., in the Chemistry Theatre.
6th	M.	4.30	Applied Physiology Lecture. Mr. SCHURR. "Tumours of the pituitary gland".
6th	M.	1.00	Clinical Lecture. Dr. FORMAN. "The skin and the gut".
7th	Tu.	1.00	Clinical Lecture. Dr. STAFFORD CLARK.
8th	W.	4.45	Science Club. Speaker: Dr. I. MACDONALD. "Dietary Carbohydrates and Lipid Metabolism".
9th	W.	1.00	Clinical Lecture. Mr. LAWRIE. " Melanoma."
9th	W.	4.15	Physiological Society. "Sphincters of the Stomach". Speaker: Mr. P. J. DAVENPORT. Chairman: Professor J. N. HUNT.
10th	Th.	9.30	Experimental Psychology Lecture. Mr. M. F. PIERCY, M.A. Physiology Theatre.
10th	Th.	1.00	Clinical Lecture. Dr. GRIMBLE. "Syphilitic Infection".
13th	M.	1.00	Clinical Lecture. Dr. DEUCHAR. "Living with Heart Disease".
13th	M.	4.30	Lecture. Mr. MURRAY FALCONER. "Memory recording mechanisms in the cerebral hemisphere".
14th	Tu.	1.00	Clinical Lecture. Mr. READING. "Pain in the Ear".
16th	Th.	1.00	Clinical Lecture. Mr. HUDSON. "Ocular Pain".
17th	Fr.	1.00	Clinical Lecture. Professor BUTTERFIELD.

Mr. R. E. RIX

—an appreciation



Mr. R. E. Rix has retired as Dental Surgeon in charge of the Dental Department for Children, after a very long career at Guy's. After entering Guy's in 1923 he qualified L.D.S.R.C.S. in 1925 and M.R.C.S., L.R.C.P. in April, 1928. Then he was House Surgeon to Mr. Pearce and Mr. Bulleid and in the records there is this precious note from Mr. Bulleid, "I should very much like to express my keen appreciation of Mr. Rix during the time he was my House Surgeon".

He became a Registrar in the Dental Department for Children somewhere about the end of 1928 and he has been there ever since, becoming Assistant Dental Surgeon in 1935 and succeeding Mr. Bocquet Bull as Dental Surgeon in Charge in 1946.

Myself a student and then a House Surgeon around 1929 and 1930, I have vivid memories of him as a young Registrar. He was already an excellent extractor of teeth, teaching the methods of Mr. Pearce, later Sir Frank Pearce. He was already a competent surgeon in theatres. He was already an excellent anaesthetist in the Gas Room. Indeed, in the Gas Room he often had to be both the dental surgeon and the anaesthetist, after receiving a note on arrival at the Front Lodge from each of his chiefs asking him to deputise. But all these are easy things achieved by many with a little orthodox training. It was orthodontics that attracted but worried him, for like everyone else at the time, he had been taught false theories and he was learning techniques where there was no one to teach him.

How to describe the changes in orthodontics since that time and Rix's part in those changes?

First—technique. In the early 1930's, stainless steel was coming in and we had no efficient means of joining two pieces of stainless steel; welders were exciting but primitive (and ours was placed in the Prosthetics Department where the students of the day attempted to make their own jewellery), soldering was uncertain and soldered stainless steel lost all its good properties. Rix found the way to wind a thin piece of wire round a thicker piece to give a firm joint without loss of properties. From this discovery he was able to design a whole series of neat appliances, well ahead of their time and in some cases still used.

Next—recognition of the failure of earlier methods and the disproving of the incorrect beliefs underlying them. Here Harold Chapman's fine paper in the middle 1930's were a foundation for a new and much more realistic approach to treatment. In practice at Guy's it meant that this change took place without difficulty. Indeed, there is a story, how true we do not know, that the Dental Surgeon found out by accident that his stated plans of treatment had been completely altered by his Registrar, Rix. It is said that neither ever mentioned the matter to each other but the Dental Surgeon thereafter showed wisdom and changed his methods. Registrars should be very sure of their ground before following Rix's example over this.

Then in 1946, over about the next ten years, came the revolution over aetiology and this was Rix's field. His paper, "Deglutition and the Teeth" (January 1946) was the starting point. From the apparently simple observation that some children swallow with the cheek teeth together and some with the cheek teeth apart, Rix was able to draw the appropriate orthodontic conclusions and from this everything else followed, affecting as it has, orthodontic and prosthetic practice and, in fact, all branches of dentistry. His paper, "Some Observations upon the Environment of the Incisors" (October 1952) added more valuable material. His gift for observation and his linking together

of observed facts have shown a touch of genius. Because he has never gone into print until he has known something for five years or more, his papers show a complete comprehension, where other people deal in bits. To the best of our knowledge, Rix has only had to modify, and that in a minor matter, one sentence in all his published writings. I am sure Rix would agree that the support he had from Professor Whillis during that period was a great help to him.

Of course, Rix was awarded his F.D.S.R.C.S.Eng., and when they came, the D.Orth.R.C.S.Eng. and the D.D.O.R.F.P.S.Clas. Of course, he was an Examiner for the B.D.S. London and the M.D.S. and the D.Orth.R.C.S. and the D.D.O.R.F.P.S. Of course, he has been a member of the Council of the British Society for the Study of Orthodontics in various capacities. He is shortly to embark on a second term of office as President of the B.S.S.O.—a very rare honour. He has also had the honour to be President of the European Orthodontic Society. At Guy's he has been Chairman of the Dental Council and Deputy Chairman of the Dental Committee and a School Governor. His advice in recent years as a part-time member of the Dental Estimates Board must have been of quite exceptional value. But all this committee work does not represent the man. When we think of Rix we think of an unspoilt and modest, gentle, kindly man, with honesty of purpose and a real flair for observation that has made him the greatest man in orthodontics in his generation. We are sure that the support he had from his charming wife, his family life and his beautiful country home have been of the utmost value to him.

Those who have worked under him acknowledge their debt and will continue to listen for the pure orthodontic wisdom that he lets fall. When Mr. Rix retired we received many warm and interesting letters from his old House Surgeons. I close by quoting from one of them: ". . . In these days of empire building in dentistry as a whole, the ' extension of the frontiers ' and the use in the literature of long sentences that have to be read three times and often interpreted with the aid of a dictionary, to say nothing of triangles, angles, lines and figures that look like a collection of logarithm tables gone wrong, I say to myself, ' Thank God for the Rix-es in this world ' ".

K. E. PRINGLE.

SURGICAL BEAUTY -the nose

by Patrick Clarkson M.B.E., F.R.C.S.

A recent article in the *Daily Mail,* in which I was very anonymously quoted, or rather misquoted rather widely, makes me feel that some surgical expression of opinion on this subject is overdue. The nose, of course, is the chief feature of the face and does to some very large extent determine the beauty of that particular face. Nevertheless, we must not forget, as Mario Gonzales-Ulloa[1], a leading Mexican plastic surgeon, stressed in a recent clinical lecture at Guy's, that, to use his own words, "A face in any determined region of the world is beauteous only in so far as it reflects the culture of that particular area. Thus, in a sense, we cannot provide a canon of beauty as has always been the dream of so many artists." Ulloa points out the need of integrating the size and proportions of the different areas of the face in trying to obtain ideal canons of facial architecture. The nose has certainly been the site of the earliest attempts at surgery for improvement of appearance. These were done by Susruta[2], who apparently, with his pupils, worked throughout more than one generation in India sometime between 500 and 3,000 B.C. He devised the method of reconstruction of the nose for those Indian ladies without noses (having lost them as public punishment for a misbehaviour, and his work in life was to restore the nose whose removal was a punitive mutilation). The importance of the nose as indication of a man's character is part of European "mythology". Cyrano de Bergerac gloried in his large nose, Rostand[3] considered that the large nose he had given him indicated that he was generous, fertile and courageous. Today, perhaps unfortunately, if a man really has a big nose no amount of quotation from Rostand will reassure him that he is silly to want to change it. Nevertheless, a large and well-defined nose certainly stamps the character of the man and gives strength to it. Many must have been struck by the similarity of bony feature of the two English colonials, Mr. Smith and Mr. Washington, who have signed declarations of independence. Within limits when the proportions of a human nose are not ideal, they can be improved by surgery to conform more closely to ideal standards. Superficial scars or growths and even disproportions of the tip can mostly be modified by surgery to make the nose conform more closely to a theoretical ideal, but it is chiefly on the bony framework that such surgical attacks must be made.

What is an ideal nose? Well, as I have said, it is the chief feature of the face. The nose, in fact, constitutes the middle third of the face and should be equal to the vertical height of the upper third, i.e., the forehead and the lower, i.e., from the columella to the lower border of the chin. An ideal nose should have a bridge-line which measures 5 cms to 6 cms., depending on the vertical height of the face concerned, the bridge-line should be straight and symmetrical, and this

bridge-line should be slender—about a cm. broad—from glabella to tip, depending on nasal bones and partly on conforming lower cartilages. It should make a uniform angle of 30° to 35° with the plane of the face, or with a line passed vertically down the nasion. Thus, to quote Ulloa, this line is the meridian 0° while the equator passes through the lower ridge of the orbit to the upper ridge of the external auditory canal. The angle of the nose should be about 30°. Most of the acknowledged beauties throughout the ages and the portraits by acknowledged masters conform to this standard of angle. It may certainly be less than this but not much less. Below 25° the nose is definitely flat, above 35° going towards 40° it becomes quite unduly prominent or perhaps even one of those keel-shaped noses which attract attention and earn their possessors many unkind nicknames from childhood onwards and are such a definite handicap to the appearance of any woman. It goes without saying that the soft tissues must conform to reasonable and independent standards of beauty. Thus the texture of the skin must be relatively thin and not contain excessive sebaceous elements. The colouring should conform to generally accepted English standards of complexion. It is, therefore, apparent that many patients who want a beautiful nose cannot be given one because their skin texture as well as their general facial proportions are unsuitable. The choice of patients for a nasal operation for appearance presents difficulties. Many patients seeking rhinoplasty are poor psychological risks and have a psychiatric background[4]. Surgery for the most part has little to offer them. They are disappointed in the end result for a number of obscure psychological reasons and should on the whole be excluded from surgery except when they have a manifest deformity whose reduction is entirely practicable.

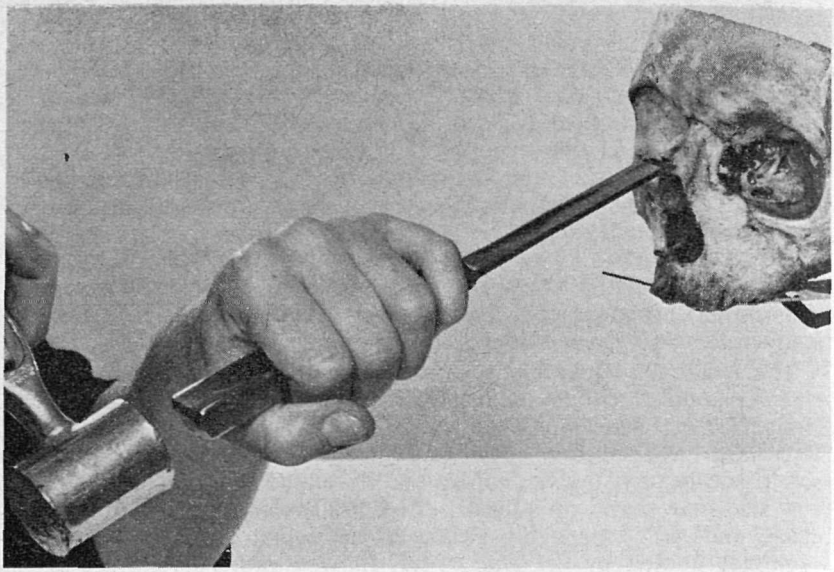
These standards, a straight, rather slight nose, of a certain size and shape, are those of Aryan beauty, chiefly Greek. What about African and Asian noses? We all know that they have flat bridge-lines and rather bulky, flared nostrils, yet there must be a nose of African type which is beautiful by ideal absolute African standards. I have often had Africans and Asians wanting changes in their noses. They always ask for an on-lay graft to build up the bridge and a reduction of the nostrils. This does produce a slightly better looking nose—by my standards—but I am quite ignorant of where I should look to find an authoritative account of absolute African or Asian standards of beauty. Thus, one Ghanese girl whose sister was worried about her bosom, wanted me to do something for her nose, but, whereas the sister was quite clear that all she wanted was, indeed, a full Californian bosom which was perfectly practicable, what she wanted was a more beautiful nose which would satisfy the world, and she was unable to make it quite clear to me what the changes she wanted were. She felt that I was rather stupid, and in any case we never came to any firm agreement. But, it remains a fact that Asiatic and African noses can only be improved up to a point by building up the nasal bridge-line by an on-lay graft (a split rib graft is probably the best) and by reducing the bases of the nostrils by simple planned excisions. In this question of facial and, particularly, nasal

beauty, the reader is referred to Kenneth Clark's "The Nude"[5] where, of course, he is particularly full and clear on the standards of beauty for the bosom. But standards of beauty in general emerge from a thorough reading of this book.

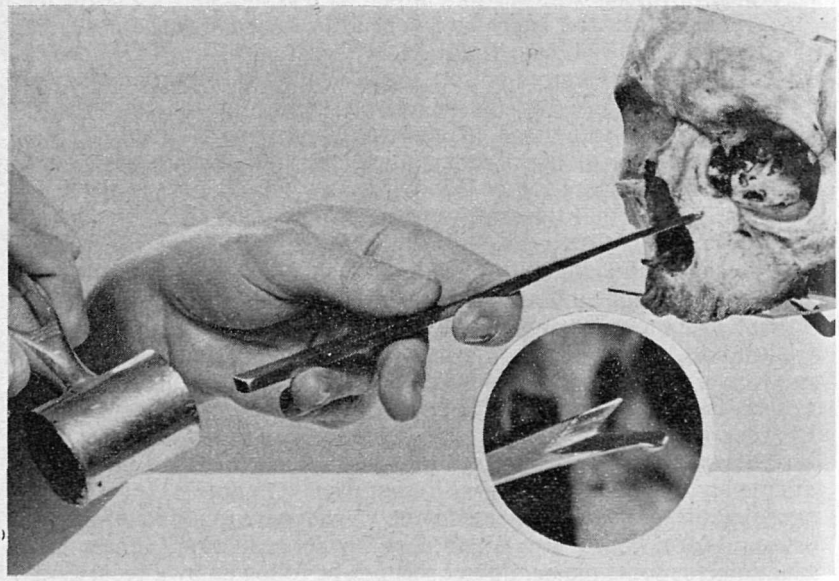
Beauty of the face can be "soft tissue" beauty or bony beauty. The classical facial bony proportions give a somewhat heart-shaped form to the facial skeleton: broader across the malars and narrower down towards the chin which neither projects beyond the vertical line drawn through the nasion nor recedes behind it. When it either recedes or projects it can be corrected either by on-lays of one of the modern foreign body plastics or by operations on the mandible. This should bring the chin into the appropriate position. This work is much helped by ortho-dontic co-operation.

The *Daily Mail* gave many striking examples of ideal beauty. The classic examples of bony beauty for many years has, of course, been Greta Garbo. Miss A. Gardiner has very nearly perfect bone structure. She has also, to a very high degree, those elements which I call soft tissue beauty, that is, colour and texture of skin, colour of eyes and size and shape of mouth. Miss E. Taylor's qualifications are clear, and she thoroughly deserved her photograph. The other examples quoted by the *Daily Mail* show a rather pristine quality and an emphasis on classical bony structure which dominated all, in black and white print photographs, and overshadowed the elements of soft tissue beauty in the photographs. Thus the very striking photograph of Miss Kelly made her nose unduly dominant although it conformed obviously to ideal standards. It was in length equal to the other thirds of the face, from the forehead to the root of the nose and from the tip of the nose to the base of the chin. I am sure that in real life the other features of soft tissue beauty entirely complement her bony proportions, but the sharpness of line of the photograph overshadowed the soft tissue elements of her beauty.

The technique of nasal remodelling or rhinoplasty. This is not an account of the operation of rhinoplasty but merely of its objectives. Let it first be said that surgically speaking there is no such thing as an easy rhinoplasty. Getting well-defined lines can be a matter of very great precision and difficulty. As in squash, there is a day when all your drop shots come off and another day when none of them will. It is the same to some extent with noses. On a good day they are a positive delight to do, on others they are frustrating and provoking, with blood everywhere and the certain knowledge that the end result will not be an ideal one. There is another factor outside surgical control which also very definitely influences the results. This is the amount of fibrous tissue, which varies from patient to patient, which individual patients lay down in healing within the nose. Obviously, this is quite unpredictable and some patients lay down excessive amounts of fibrous tissue and form blobby tips which need further reduction. These later reductions for some reason do not seem to be followed by a recurrence. The objectives of surgery which is done under general anaesthesia are: a line is drawn along the bridge-line representing an angle of 30° from the root of the nose to the plane of the face or to the plane that passes vertically at right angles through the nasion, therefore, this line starts



(1) Removing the hump by a dorsal chisel.
This is 11 mms. wide and passes through the front septum and nasal bones at an angle of 30° to a line dropped vertically from the nasion.



(2) The infracture by the use of the Swiss bifurcated osteotome.
This method osteotomy, saws or single osteomes, may be used, but has not the certainty or accuracy of the Swiss osteotome which is considered preferable for accurate work to other methods.

Pre-operative as a Spinster: Typical large hooked nose.

Post-operative and Married: This patient shows particularly well not only a nose which now conforms to aesthetic and ideal standards, but also the effects on temperament which such a change has promoted.

The post-operative nose has an angle of 30° to the plane of the nasion and is in length about a third of the vertical diameter of the face. The effects of all rhinoplasties are by no means as happy as this.

just below the nasion about 2 cms. in front of this plane of the face, which is judged by eye. By a broad chisel passed along this line inside the skin the hard tissue in front of this angle is removed. Subsequently, the nasal septum and lateral cartilage anterior to the plane of 30° are dissected out, care is taken to see that the tip of the septum is not left projecting along this fresh bridge-line. The septum is then shortened for 2-4 mms., to shorten the nose to the required amount. Great care should be taken not to remove too much septum. A tip-tilted nose is seldom liked for long by a patient and should indeed not be prescribed except at her express wish against which she is advised. Having removed the crest of the bridge of the nose, it is essential to do an infracture to the nasal bones. This is done by a special osteotome. Those plastic surgeons who continue to saw their way through the nasal bones are asking for an early coronary. A light but snugly fitting plaster is then applied and worn for 7-10 days. The nostrils are plugged for 2-3 days. Full social and economic life may be resumed within 2-3 weeks.

I enclose a photograph of a patient for whom these objectives were obtained. She does exemplify by her expression the way in which the whole nature of a woman, especially one with a big or drooping nose, can be changed for the better. This standard of result can, of course, not be obtained for everybody. The article is submitted in the hope that the question of these bony standards upon which nasal beauty, the chief feature of the face, rests, is worth study by all those interested in facial surgery.

To summarise, an ideal nose should be not more than a third of the vertical height of the face. This is generally about 5-6 cms. from nasion to nasal tip. The bridge-line should be straight in profile, slender and symmetrical. It should make an angle of 30° with a vertical line dropped through the nasion and with the plane of the face. I support Ulloa's belief that the proportions of the face should be integrated with the face as a whole and this ideal nose bear appropriate relationship to the length of the other thirds of the face and that in addition to the nose making an angle of 30° with the plane of the face the chin should be neither projecting nor receding beyond a vertical plane dropped through the nasion.

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CORRESPONDENCE

Chronic

SIR,—The pessimism of your leader (30th October, 1965) concerning the shortage of accommodation for incurable and chronic illness is to some extent justified. From the point of view of these patients, however, matters have been improving in the last 20 years. It is becoming increasingly recognised that psychological stimulus can often compensate for physical disability, even if this is progressive. In the older age groups, recovery from physical illness, including destructive lesions like strokes, may be significant, albeit slow and gradual over several months. It has been found that proper appreciation of the clinical conditions, together with planning of a rehabilitation programme which takes account of physical, emotional and environmental factors enables many patients to exhibit sufficient recovery to avoid permanent placement in a "chronic" bed.

It is on this basis that the justification emerged for the establishment of regional geriatric departments. The organisation of such a department is tailored to the changing needs of the elderly patient in hospital. It should be equipped with staff and facilities to deal with medical emergencies of old age. Beds should also be available for assessment of remedial disabilities, which may require the patient to stay in hospital for several weeks or months. The department must take responsibility for a larger number of long-stay patients than general wards. For example, in a unit of 88 beds, 45 were found to be occupied by long-stay patients. In New Cross Hospital, 88 of 153 beds are occupied by permanent physically or mentally disabled old people. Many others in the active wards will by nature of degenerative disease become long-stay patients.

The realisation that the outcome of chronic illness is improved by planned management has its educational implications. Geriatric nursing has been shown to demand certain specialist skills as well as basic nursing techniques. A doctor or student who has worked in an active geriatric department should have a wider grasp of bedside clinical techniques as well as a broader approach to the complexity of problems of the disabilities of old age which occupy much of medical practice to-day.

I agree with your suggestion concerning the rotation of nurses through long-stay wards, but I would include the active and assessment geriatric wards. I think that there are many clinical lessons to be taught there also for the undergraduate medical student.

Yours, etc.,

J. ROSIN.

Geriatric Department,
New Cross Hospital,
S.E.14.

Neurotics

SIR,—I would like to take up a point mentioned in G. L. Davies' article, "Neurotics," published in the *Gazette* on November 13th.

Dean Swift did not produce his satires "under the guise of writing stories for children." Nearly all his books were published anonymously, and the only work of his vast collection of writings for which he received any money was "Gulliver's Travels," "A Tale of a Tub." "Gulliver's Travels," together with most of his other books and his numerous ironical pamphlets about politics and the Church, were written as satires, which was, of course, what they were.

He certainly was not mad for the major part of his life, but from an early age he did suffer from a form of vertigo. Perhaps it was this condition, which considerably worsened in 1738, and his exasperating feeling of contempt for the state of humanity, as summed up by his own epitaph, "Where fierce indignation can no longer tear his heart," which tipped the scales towards insanity that struck him in the last part of his life, when he wrote relatively little.

That Swift wrote his own epitaph, and in it realised his own exquisite perception of human affairs would class him, if anything at all, as a psychoneurotic and not a psychopath.

Admittedly he wrote much about madness, but this does not entail that he was mad any more than a person who writes about murder is a murderer.

He was, however, aggressive, to the extent that he alienated some of his

friends, Dr. Johnson, Thackeray and Macaulay among them, but this aggressiveness was probably due to upright and noble qualities (such as the men whom he attacked in his blistering satires did not have), that had been fouled by bitter experience. It is not so uncommon to see this to-day, when people, especially maturing adolescents, realise, or are made to realise that the world is not the beautiful, wonderful and uncorrupt place that they thought it was. Some can take this realisation without permanently disturbing their emotional equilibrium, while others shield themselves behind neuroses. Swift was no doubt in the latter category, his "shield" being his aggressiveness.

His satires may have been called many things, coarse, harsh, and even revolting, but haven't these very words been levelled at television programmes such as "That was the week that was," "Not only but also," and "B.B.C. 3"? Yet the writers of these programmes aren't branded as Psychopaths. Neurotics may be, but psychopaths no.

That he hit so hard and so effectively at some of Man's Beliefs and Institutions, which are so often irrationally protected from such criticism, however genuine it may be, was most likely the major cause of the accusations of insanity that were, and are made against Swift.

Yours, etc., STEPHEN ORLANS.

Dental School,
Guy's Hospital.

Just Once . . . ?

SIR,—Guy's Hospital Rugby Football Club, 102nd Season, February 6th, 1946: Cambridge University; 9 points, Guy's Hospital, 13 points, following a 6—6 draw at H.O.P. on the 24th October of the same season.

Mick Gray, standing in for Tom Lewis at full back, had a great game and as on many occasions that season, the forwards "bustled the opposition to good effect." True, 1945-6 wasn't to be cup-winning year. How often can the winners boast an England centre triangle of the Hall, Scott and Bennett calibre? St. Mary's proved just too good for Guy's in the final. This very keen Guy's team did, however, beat Wasps (twice), Harlequins, Richmond/Blackheath, the South African Services Touring XV, Roslyn Park, and draw with Coventry, away.

I wonder how many others of this very happy side are still foolish enough to be playing?

Yours, etc., I. H. HILLIAM.

Carroll Cobb,
Carroll Avenue,
Ferndown,
Dorset.

Or Twice . . . ?

SIR,—Guy's have beaten Cambridge University on another occasion. On January 27th, 1926, to be precise. The score was 17 points (1 goal, 1 penalty goal and 3 tries) to 6 points (2 tries). There is an account of the game in the *Gazette,* 1926, volume 40, p. 98.

Yours, etc., WILLIAM HILL.

The Wills Library,
Guy's Hospital,
London Bridge, S.E.1.

Doris Farmer

SIR,—I should be most grateful if you would allow me through the medium of the *Gazette* to thank all members of the staff at Guy's and all those who qualified dentally during the period I was in the Medical School Office and who subscribed to the magnificent cheque with which I have been presented on my retirement from Guy's.

My retirement will be all the more pleasant in the knowledge that so many friends have also sent kind messages, and I do most sincerely thank everyone.

Yours, etc., DORIS L. FARMER.

25, Wincrofts Drive,
Eltham, S.E.9,

GUY'S AS A DISTRICT HOSPITAL

A. H. Burfoot

On 26th October, 1965, the Ministry of Health issued the following brief press notice:

> "The Minister of Health has decided to unify under the Board of Governors of Guy's Hospital the administration of Guy's Hospital and the hospitals now administered by the Bermondsey and Southwark Hospital Management Committee. After 1st November, 1965, the Board of Governors will be responsible for providing hospital and specialist services for the area."

This notice was the first formal indication to the public at large of the successful conclusion of a long period of discussion and negotiation in which the South-East Metropolitan Regional Hospital Board, the Bermondsey and Southwark Group Hospital Management Commitee, the Ministry of Health and Guy's were primarily concerned.

The Bermondsey and Southwark group of hospitals was brought into being by the National Health Service Act in 1948 when St. Olave's Hospital, New Cross General Hospital, the Dunoran Home, the outpatient facilities at the Grange Road Public Health Centre and at the Southwark Chest Clinic were all grouped together under a common administration.

St. Olave's Hospital in Rotherhithe was formerly a London County Council hospital. Between 1948 and 1965 additional beds have been opened and considerable improvement work carried out so that now it is a busy acute general hospital with 15 wards providing a total of 330 beds covering the main specialities with supporting diagnostic and treatment departments. Included in this number are 32 beds for mental illness with day hospital facilities which were provided in 1960. St. Olave's Hospital is currently recognised by the General Nursing Council as a nursing school for the full State Registered Nurse course.

New Cross Hospital off the Old Kent Road was originally a fever hospital opened in 1877 and reconstructed at the turn of the century. In 1941 the severe bombing of the neighbourhood brought about its closure, and it remained virtually empty and derelict for some 10 years. Shortage of money prevented any development of the hospital until 1952, when the Management Committee opened one ward for the accommodation of chronic sick. Progressively more beds were brought back into use and an assistant nurse training school was opened. In 1953 consultant clinics were commenced, and by 1956 an operating suite was completed. In 1964 a very well equipped rehabilitation unit

was brought into use and there are now at New Cross 304 beds covering general medicine, orthopaedics, accident and rehabilitation and geriatrics.

Dunoran Home is a country house with three acres of ground at Bickley, near Bromley. It was converted to its present use by the interdenominational Brook Lane Medical Mission and cares for some 40 younger adults with physical disabilities preventing them from being looked after in the home, although mentally alert and able to communicate with one another. It retained its special character under the administration of the Management Committee and has sought to preserve a homelike atmosphere in which patients are made to feel and, in fact, to be individual members of the small community in which they find themselves.

Both St. Olave's and New Cross Hospitals have been associated in various ways with Guy's over a number of years. At St. Olave's it was the custom that some of the senior consultant posts were held by Members of the Guy's Staff. Mr. Davies-Colley was, for example, on the Staff of St. Olave's for many years. More recently, Mr. Wass, Dr. Baker, Mr. Batchelor, Mr. Reading and others have all held appointments. During the war years Guy's medical students visited St. Olave's on an informal basis, and coaching was carried out. Since 1952 teaching has been formally organised at St. Olave's with weekly surgical ward teaching rounds following the appointment of the first surgical senior registrar to hold a rotating registrarship between Guy's and regional hospitals. Final Fellowship classes have been held at St. Olave's since 1954, and the Clinical Examination for the Treasurer's Medal has been held at the same hospital for about the same length of time.

At New Cross Hospital Guy's provided the nursing staff for the male medical ward which was opened in April, 1956, the beds being under the care of Dr. MacLean. In October of that year, Guy's nurses were withdrawn from Orpington, where they had been working since the wartime evacuation. It was then possible for Guy's to nurse 158 surgical beds at New Cross under the care of Guy's consultants. This arrangement continued until May, 1962, when New Guy's House came into full use for surgical patients and the Guy's nurses were required at their parent hospital. There followed a reallocation of the beds at New Cross to provide for Guy's a homeward bound accident and emergency service, a rehabilitation unit and hostel beds for radiotherapy, all nursed by New Cross staff. This was a good example of the co-ordinated provision of services between Regional Board, Management Committee and Teaching Hospital.

The links between Guy's and the Bermondsey and Southwark Hospitals which have existed over these years have on more than one occasion led to suggestions of a more formal association. Before 1948 there was a tentative proposal, not in the end pursued, that Guy's and St. Olave's should join together. More recently the need for a reorganisation of the hospital groupings in this south-east corner of London became increasingly evident and especially with the growing awareness on the part of the undergraduate teaching hospitals in

London that the role of the teaching hospital was changing. In the Hospital's Report for 1962, this was referred to in the following extract:

> " Many teaching hospitals are considering whether by some reassessment of their function they could also offer for their own area those services associated with a district general hospital which they are not already offering. This would possibly entail provision of geriatric beds and more maternity beds and also the acceptance of all patients as they were referred by general practitioners for in-patient treatment."

In these words was the first public suggestion that Guy's should provide a full district service to the people in its own particular area. At about the same time a considerable amount of work was undertaken by Professor W. J. H. Butterfield in his survey sponsored by the King Edward's Hospital Fund for London as to how and why patients came to Guy's. There had long been a feeling that as local hospitals in the suburbs of London and the adjoining countryside were rebuilt, there would be many people hitherto coming for treatment or advice to the London teaching hospitals who would now prefer to obtain this at their own local hospital. The survey showed that rather less than half the out-patients at Guy's came from outside the area of Bermondsey and Southwark and the immediately adjoining boroughs. Should the suspected decrease in the number of patients coming from further afield take place, these figures gave warning of the effect it would have on the work which this Hospital must undertake in continuing to fulfil its primary functions of treating patients and of training doctors and dentists of the future as well as being a centre of research and advance in medicine and dentistry. At about this time Dulwich Hospital was transferred from the Camberwell Hospitals Management Committee to King's College Hospital following an association for teaching purposes which had existed for some years. This transfer reduced the size of the Camberwell group considerably and the need to reshape the pattern of hospital organisation in this part of south-east London became increasingly apparent. This coincided with public criticism directed at the seeming lack of effective co-ordination in the planning of hospital services in the centre of London. The greater part of these are provided by the twelve undergraduate teaching hospitals, although there are also Management Committees whose areas come towards the centre. Each teaching hospital is under the control of its own Board of Governors responsible directly to the Minister of Health while the services provided by the Management Committees are within the regional plans of the four Metropolitan Regional Hospital Boards. With a multiplicity of authorities responsible for hospital services, there is the temptation for each to provide the widest range of highly specialised units both in teaching and non-teaching hospitals. Views as to how better co-ordination can be achieved in the provision of hospital services in the centre of London to prevent overlapping and duplication range from the creation of a central London hospital authority to the inclusion of the teaching hospitals within the Regional Hospital Boards' organisation on the Scottish pattern. To some there

appears to be a need not only to improve co-ordination of hospital and specialist services, but also to bring a closer relationship between these, the general practitioner services and the health services provided by the local authorities. For any major change in the present distribution of responsibility in the health service organisation, legislation would be needed and major change would undoubtedly bring with it a major clash of opinion as to which would be the better course to follow. Out of the necessity to move slowly has developed what may be a practical way of preserving the necessary degree of initiative and independence of outlook of a teaching hospital while integrating the services it provides into a more rational plan for the patients who are its responsibility.

On the proposal of the Minister of Health, closer liaison between the Undergraduate Teaching Hospitals, the four Metropolitan Regional Hospital Boards, the University, local authorities and Executive Councils, will now be achieved by Co-ordinating Committees which have been set up one for each quadrant of Central London falling within the four Metropolitan Regional Hospital Board areas. These will advise both Teaching Hospitals and Regional Boards on the planning of hospital and specialist services in their areas, and in their day to day discussions will be in close contact with the Ministry of Health.

It is against this pattern that the amalgamation of Guy's with Bermondsey and Southwark must be seen. Before this took place the Governors gave an undertaking to the Minister which included the provision of virtually a full range of hospital and specialist services for people living in the former Borough of Bermondsey and parts of the former Boroughs of Southwark, Deptford and Camberwell. They also agreed that as the needs of the people in this area for hospital and specialist services changed, they would ensure that the services provided continued to meet the changing needs. This does not of course mean that patients from further afield will not still come to Guy's or that patients within this area must necessarily regard Guy's, New Cross or St. Olave's Hospitals as the only places in which they may obtain treatment. In the foreseeable future it seems likely that patients from all over the country will continue to be attracted to the teaching hospitals.

As from 1st November, 1965, all members of the staff of the former Management Committee automatically became members of Guy's staff, sharing the same responsibilities and privileges. St. Olave's and New Cross Hospitals have, however, over the years, been supported by the goodwill and enthusiasm of the people in their immediate area and it seems important that these local associations should be preserved. One of the purposes of the amalgamation is to ensure that all the facilities available in the larger group are properly integrated and a comprehensive range of hospital and specialist services made available to the people of the area in the most efficient way. This can be achieved only under a common administration and a small co-ordinating committee has been set up for this purpose. Nevertheless, the Governors have felt that they should, within the overall policy of the Board, delegate as much authority as possible to individual hospitals. They have therefore set up two further standing

committees, one for St. Olave's Hospital, which will also be responsible for the Bermondsey Chest Clinic and the other for New Cross Hospital, which will be responsible in addition for the Dunoran Home and Southwark Chest Clinic. These committees, under the chairmanship of Mr. Richard Hayward and Mr. Donald V. House respectively, consist of five Members of the Board with power to co-opt additional members who are not necessarily Governors. All the former Members of the Hospital Management Committee who were able to continue to give service to these hospitals have now been co-opted to one or other of these two new committees. Mr. Pemberton, who was formerly the Group Secretary, has become the administrative liaison between them and the central administration of the Board of Governors.

The purpose of this article has been to sketch briefly the events and changing ideas which have led up to the Minister's press statement of 26th October last, and to outline the administrative arrangements which have been made for the immediate future without attempting to look further ahead. As the negotiations moved towards a successful conclusion it was heartening to all concerned that they were taking place with so much goodwill on all sides. We all know that there will be many problems to solve and a great deal of thought will be needed to secure the best from the possibilities which now exist.

NOTICES

Boat Club Dinner

This is provisionally fixed to take place in the week starting Monday, 6th December. I shall be very pleased to hear from anybody who would like to come, and can be reached c/o The Boat Club, in the East Wing. A telephone number is very helpful in any enquiry.

Secretary, The Boat Club.

Theatre Club

Tickets are still available for this term's production, " The Waters of Babylon," by John Arden, which will run for five nights from November 29th to December 3rd. There are usually a few empty seats on the nights of the performance, so if you have an evening free, please come along and we will find a seat for you.

Christmas Ball

Following University tradition, we are holding a formal Xmas Ball in the East Wing on Wednesday, 8th December, 8 p.m. to 1 p.m. to the Keith Porter Sextet and "The Idle Hands." A cold buffet will be served. Tickets will be available from East Wing Porter, R. Brangwyn-John, L. Turner, R. Dewsnap and myself.

J. G. Payne, Soc. Committee.

Guys' Hospital Clubs Union
The Rose Ball

The Rose Ball will be held on Friday, 21st January, 1966, at the Savoy Hotel. The music this year will be provided by Tommy Kinsman and his Orchestra, and seven New Orleans Jazzmen. In addition to the usual box of tricks of Tombola and raffle, a cabaret star is being flown in from Italy. All members of the hospital staff, medical and dental students, nurses and physiotherapists are most cordially invited to make it the gayest evening of 1966. Tickets and table reservations for 8, 10 or 12 couverts are obtainable from Mr. J. Goodliffe, c/o The Medical School.

J. COLLINS,
M. A. Q. JAMIL,
Hon. Rose Ball Secretaries.

MUSIC CLUB

The name of Zoltan Kodaly is by no means unfamiliar in this country, though his visits have become less frequent with advancing age, and his works, particularly the choral ones, are still insufficiently known by English audiences. Kodaly is the only surviving member of a triumvirate of Hungarian composers who were all born about 1880. The other two, Bartok and Dohnanyi, pursued widely divergent courses, Bartok developing into one of the most vital and original figures in 20th Century music, Dohnanyi clinging tenaciously to the example of Brahms and Strauss, but at the same time creating a series of delightful romantic works culminating in the splendid Variations on a Nursery Song. Kodaly, too, went his own way. Lacking the tremendous genius of Bartok, he stuck much more closely to the direct influence of folk music, and particularly of folk melody (for Bartok, rhythm was the great folk characteristic, and he seldom quoted Hungarian tunes in his serious works). At the same time Kodaly became interested in music for children, and his work in the educational field has been as vitally creative in its own way as Britten's.

Kodaly's orchestral music, the *Hary Janos* Suite (which actually comes from an opera of the same name), the various sets of dances, and the splendid Peacock Variations, turns up quite often in London concert programmes, and it comes as something of a surprise to discover that his choral works are more numerous. Perhaps one can go further, and say that they are also more characteristic, at least in their distillation of a genuine Kodalian idiom in which folk music is a relatively subordinate influence (Bartok, too, wrote some fine choral works that are seldom heard in England). The *Missa Brevis*, which is one of the works in the Guy's concert to be given in Southwark Cathedral on December 14th, is not entirely typical, because for once folk influences are completely banished, and we have a work that sounds more than anything like a kind of localized Bruckner. If you hear this mass for the first time, you'll be struck by the tremendous power of Kodaly's structure, and the relentless weight of his vocal lines, many of which are very slow-moving. The orchestra seems to imitate a huge organ (it does in fact do this for the work was originally composed for organ accompaniment, and the composer built the orchestral score from the organ part in 1950). Listening to the mass in a large cathedral, one can sense a strong link that often seems to be present in the sacred music of central and eastern Europe.

The rest of the concert, incidentally, is devoted to Bach, and includes the wonderful Fifth Brandenburg Concerto, with its virtuoso part for the solo harpsichord, and the Magnificat which Bach wrote soon after his arrival at Leipzig in 1723. The spirit of the Magnificat is quite different from that of Kodaly's Missa Brevis, for this is a tremendous shout of jubilation, in which Bach identified the joy and goodwill of Christmas with his own happiness at being once again able to compose music for his beloved chorus and organ.

This concert will be held at Southwark Cathedral on Tuesday, December 14th, at 7.30 p.m. Admission is free. There will be a silver collection for U.N.I.C.E.F.

REVIEWS

A GUIDE TO DISEASES OF THE NOSE, THROAT AND EAR FOR GENERAL PRACTITIONERS AND STUDENTS

by E. G. Collins. E. & S. Livingstone Ltd. 359 pages. *Price* 36*s*.

This book supplies the basic knowledge of the speciality with clarity. The text is in a conversational style, and the illustrations are good. Although it certainly covers what the medical student might be expected to know, it, of necessity, omits discussion of more recent operative procedures and specialized investigations.

The speciality has been discussed under the headings of upper respiratory tract and upper alimentary tract with the Eustachian tube regarded as the connecting link to the middle ear cleft. This physiological approach is more stimulating than the traditional description under anatomical sections as it conforms to clinical practice. The inclusion of differential diagnostic tables is a useful adjunct to the text. It is unfortunate that the classification of carcinoma of larynx into "intrinsic" and "extrinsic" types is retained as it perpetuates some confusion in the classification of this neoplasm.

K. E. THOMAS

DENTAL PHARMACOLOGY

by George W. Pennington. Blackwell Scientific Publications, Oxford. pp. 158 vii. *Price* 27*s*. 6*d*.

In his preface to this slim volume, Professor Pennington states that it was written "with the intention of supplying in addition to the essential pharmacological knowledge which the dentist needs to know, an account of that background to pharmacology which is so often lacking in the education of the dental student." The first chapters are devoted to the general principles of pharmacology and the remainder to groups of drugs of dental significance. Inevitably full discussion of some topics is not attempted, but in this book brevity is not coupled with simplified dogma; for example, the reader is left in no doubt that the modes of action of many drugs are complex processes, still imperfectly understood. There are useful suggestions for further reading in general pharmacology at the end of each chapter.

The book does provide a sound, clearly written background to pharmacology for the dental student and a satisfactory account of those drugs used in general medicine which may complicate the practice of dentistry. It is less certain that it covers adequately the pharmacology of all the drugs which the dentist himself prescribes. The drugs most commonly administered in dental practice are local anaesthetics, analgesics and certain antibiotics and the student requires at least as much information on these as his medical colleagues. Some of the sections describing these could therefore be extended with advantage in future editions, particularly that on local anaesthetics; after all, the dental student is to become a master anaesthetist of the jaws and should have detailed pharmacological knowledge of the drugs he uses. Exclusively, dental remedies are hardly touched on at all and a fuller account of the pharmacology of the fluorides with appropriate references would be a valuable addition.

Some very recently introduced drugs, including cephalosporin are described, but it is surprising to find no mention in the text of such newer drugs as methohexitone sodium and prilocaine which are now used in many dental surgeries. There are a few misprints.

The dental student will require further reading in dental pharmacology than this book provides; particularly in dental therapeutics. Nevertheless, it can be thoroughly recommended as an excellent introduction to pharmacology for dental students, and may well stimulate a lasting interest in the subject.

J. N. JAMES

A NEW LOOK AT GERIATRICS.

R. Kemp. Pitman Medical Publishing Co.

This little monograph is one of the series, " A new look at Medicine." As it says in the introduction, this look describes the study and prevention of morbid trends in ageing. It is really a plea to doctors to seek out and destroy

SPORT

The advent of more seasonable weather left its mark on the Hospital's sporting programme last week-end. All the hockey teams were robbed of their fixtures by rain, while an administrative error was responsible for the absence of any soccer. Mud at Imber Court reduced the 1st XV's encounter with the Metropolitan Police to a boggy brawl, where two infringements near the posts decided the issue in the home side's favour. At Dulwich, the preceding week, however, the team played a fine open game, defeating Old Alleynians by the satisfying margin of 19—3.

P. Gooder proved a worthy victor when the Boat Club held the annual competition for the Gurney Sculling Trophy. The Club is now engaged in a bitter duel with the elements in preparation for the University Winter Eights to be rowed on December 4th, for which your support is solicited.

What appears to have been another successful and entertaining Thatchings-based tour has as recently been completed—the Squash Club having the distinction of combining a little drama (greatly to the cost of the Theatre Club) with the usual run of Wine, Women and Song, plus, it is claimed, a little squash.

ASSOCIATION FOOTBALL

With the season now well under way, it has become evident that Guy's are not the force that they once were in hospital soccer. The departure of many stalwarts, whose value was not perhaps fully appreciated in their playing days, has left gaps which have not been easy to fill. It is a sad reflection that a club, who two years ago won the Hospitals Cup and reached the semi-final of the University Cup, is now unable on occasions to call upon 22 players. However, far from wallowing in past glories, Elwyn Elias has set about organising the limited talent available. The degree of success that has come so far, particularly to the 2nd XI, is a measure of his enthusiasm and of the team spirit he has engendered.

One of the first matches of the season is traditionally against the Hospital Staff. Each year the teams play twice to contest for the Governor's Shield, the winners being the side to score more goals on aggregate. The students have seldom failed to win by a margin of less than five goals, and if nothing else has been won that year, this is the one trophy they can usually sport. On this occasion the Staff won deservedly 5—1, and history appears to be in the making.

The less said about Guy's showing in the University Cup, the better. They lost 7—1 to Birkbeck College in the Preliminary Round, the side they beat last year by an identical score. Since then things have been looking up, as players have learnt to look down at the ball. Wins in the League against King's, St. Mary's and St. Bart's, and two keenly fought draws against the Royal Dental Hospital and U.C.H. have much improved the club's record.

The 2nd XI has exceeded all expectations. To date they have lost only once; victories have been achieved with astronomical scores. It is hoped that in the sterner tests to come they will continue to play as a team.

Nash and Lindridge have represented United Hospitals for the first time this season. Elias is to be congratulated on his selection to the A.F.A. XI that recently played against Cambridge University.

SPORTS DIARY

Nov. 27.—Rugby Football v. Stratford-upon-Avon. Away.
Association Football—v. Sir John Cass College. At home.
Hockey—v. Merton. Away.
„ 30.—Squash. Cumberland Cup v. Honourable Artillery Company. Away.
Dec. 1.—Association Football v. Queen Elizabeth College. Away.
„ 2.—Squash—v. Sundridge Park S.R.C.
„ 4.—Rugby Football—v. Streatham—Croydon. Away.
Association Football—v. U.L.C.
Hockey—v. Bexleyheath. At home.
„ 8.—Association Football—v. Middlesex Hospital. At home.

REPORTS AND RESULTS

RUGBY

GUY'S v. OLD BLUES

At H.O.P. 6th November, 1965.
Result: won 11—0

The Hospital kicked off into a stiff easterly wind, and although the early play was ragged, Guy's were receiving most of the ball—due largely to some clean jumping in the line-outs by Peace who was well supported by Stansfield and Davies.

In spite of this possession, Guy's were unable to gain any advantage in the threequarters as passes, hampered by the wind, were going astray. Some sound covering by the Hospital loose forwards, Williams in particular, prevented Old Blues from gaining any advantage from the loose ball.

O.B's., using the wind, persistently kicked onto our line but some sound positional play by Elliot relieved any threat of danger, and his attacking runs through the advancing O.B's. were worthy of more support.

O.B's. then took the initiative and a penetrating run by Wright (a former Hospital player) would have equalised had he not been pulled down just short of the line.

Shortly before half-time, Elliot goaled a good penalty, giving the Hospital a much needed three points lead at the changeover.

Playing with the wind in the second half, Guy's were soon on the attack, and some incisive breaks by Ross, playing his first game at centre, gave the back line the penetration that had been lacking in the first half.

From a scrum on the half-way line, Rowlands kicked ahead. Edgar, following up, kicked the ball over the goal-line and Osborne beat the opposition to the touch-down to score far out. Elliot's kick from the difficult angle was just wide.

The ball at this stage was not reaching the backs cleanly from the tight or loose scrums, and our backs were hampered by some close marking by the O.B's. loose forwards.

The early superiority gained in the line-outs was maintained however, and had it not been for a fumble on the line a good break by Sharp would have resulted in a try.

Ten minutes from time Rowlands was pulled down on the line and Guy's, gaining possession from the ensuing scrum, fed the line and Ross broke through powerfully for a good try which Elliot converted.

Cohesion—which had been lacking earlier—was now evident in the line and Ross and Osborne both exhibited good penetration. The final whistle went with Guy's well on the attack and playing far better than at any other stage in the game.

D. BARFORD

Team: D. Elliot; D. Osborne, J. A. Edgar, J. R. Ross, P. Bundred; B. Rowlands, P. J. Swift; J. E. Davies (Capt.)., C. E. Lewis, R. Starsfield, P. K. Peace, A. J. Kingdon, H. C. Sharp, K. Brown, P. A. L. Williams.

HOCKEY

GUY'S v. GRAVESEND

Result: won 2—1

Recent matches have been disappointing, either in the results or the manner in which they have been achieved. The Gravesend match is a most popular fixture and with a sunny, albeit fresh, afternoon, and a couple of wagers, Guy's were all set to improve the record.

From the bully-off Guy's hit the opponents' goalpost and just failed to score from the rebound, before a Gravesend player had touched the ball. The game settled down to a hard, fast pace, and Guy's were eventually rewarded with a goal after a good movement. The ball was passed straight out to the right wing who took it quickly upfield and centred for the centre-forward to score.

Bullying-off after half-time, Guy's again started well, but after a short time the defence came under heavy pressure from the determined Gravesend forwards, who equalised after Guy's had failed to clear a rebound from the goalie. Gravesend kept up the pressure and at one stage the ball remained in the Guy's half for ten minutes. However, in the closing stages of the game Guy's recovered their grip on the game and during a scramble in the Gravesend circle the centre-forward scored with a reverse-stick drop shot between the goalkeeper's legs. It was an extremely enjoyable game and a good result, especially as we have not beaten Gravesend for five years. It was good to see the tempo of the game kept up throughout, and the defence holding together under sustained pressure.

The Club now has a sixth member, John Crafts, playing for United Hospitals.

Team: S. Rear; D. Loader, R. Kendrick; J. Crafts, C. Brooks, M. Shröder, D. Carruthers, S. Cripps, M. Appleby, P. Bennett, C. Pearson.

BOAT CLUB

The Gurney Sculling Trophy

This is an annual event open only to present and recently past Guy's oarsmen. The trophy consists of a pair of silver sculls, donated to the Club some years ago by Mr. D. Gurney, coach and vice-president of the Boat Club.

The event took place this year early on the morning of Sunday, 14th November, in very cold but nonetheless bright conditions with perfect water. Week-end training had been suspended for the occasion, and this year the race was rowed in two divisions, to deal with the record entry. The senior division consisted of those who had previously won a sculling event, and it was hoped with the junior division to encourage those whose sculling was an unknown quantity. All races were rowed in gig sculling boats.

Divisions:

Senior
- P. Garcia-Webb-Sharp.
- S. Gregson.
- C. Soutar (previous holder).
- P. Gooder.

Junior
- All other entrants.

The course was from Chiswick Ayot to the University Boathouse, about 800 yards. P. Gooder met S. Gregson in the senior final and the latter did very well to hold Gooder to a lead of three lengths. Gooder rowed a magnificent race, with a time in the final of 1 min. 50 secs., a very creditable performance, boding well for the United Hospitals Regatta, for which he is entered.

In the junior division there was some very variable oarsmanship, luckily without submersions! P. Burton (Captain of Boats) met P. Telling in the final, which race was no exception to the previous form, being very erratic. Telling narrowly missed Chiswick Railway Bridge, whilst Burton, harried by other river traffic, built up an unassailable lead, finishing in a rather misleading time of 2 min. 40 secs.; verdict, easily.

The trophy is to be presented at the Boat Club dinner.

SQUASH

SUSSEX TOUR

Results:

v. Brighton S.R.C. Lost 1—4.

v. Middleton S.R.C. Won 3—2.

v. Chichester S.R.C. Won 5—0.

Team: J. H. Newman (Capt.), J. R. Webb, E. P. Davis, C. L. Newman, N. M. White.

This was the first time that the squash club had ventured southwards for a week-end tour; and a most enjoyable and successful week-end it was.

We arrived at Brighton to find their strongest side against us; and their own peculiar courts —which are dead slow with walls very near to salmon pink in colour. J. H. Newman gave us a good start by beating their No. 1 in four close games. The rest of the matches are best forgotten, no one really mastering the rather strange surroundings. After suitable refreshment, we eventually found our way to "Thatchings", where we were treated to a preview of the Theatre Club's forthcoming production—one member of the team informed me that it ended about 4 a.m.

Having conclusively proved that golf was not the No. 1 sport for any of us, we proceeded to Middleton for what was expected to be our toughest match. N. M. White began the proceedings with an impressively quick win. Meanwhile, J. R. Webb was succumbing 3—1 to a player who is on the verge of the Sussex county team. His was a good fighting performance. E. P. Davis, rather surprisingly, won a close match in three games. This left J. H. Newman with all to play for against a player who very recently was in the reckoning for the England team. This proved an exceptionally fast and entertaining game with the Guy's player always down, but fighting hard, only to lose in the fifth game. C. L. Newman then clinched the match for us in three quick games. The lower order who had played so disappointingly the day before, had gained us this excellent win.

On Sunday we went to Chichester feeling very much more confident. The 5—0 score suggests an overwhelming victory. This, however, was not quite the case. J. H. Newman lost a game to last year's Cambridge captain; and all the other games were fairly close. This concluded an excellent week-end's squash, with all playing very much better than on Friday.

Finally we must not forget Mr. Lewis' contribution at "Thatchings" to this most enjoyable week-end.

E. P. DAVIS

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S-MAUDSLEY NEUROSURGICAL UNIT

Applications are invited for the post of **Registrar** (middle grade) for one year, commencing on 1st January, 1966, or as soon as possible thereafter. The Unit, which is housed in the Maudsley Hospital, serves both Guy's Hospital and the Bethlem Royal and Maudsley Hospitals. Applications should be made by 8th December, 1965, to L. H. W. Paine, House Governor and Secretary, Maudsley Hospital, Denmark Hill, S.E.5.

HOUSE APPOINTMENTS

GUY'S HOSPITAL
December 1st, 1965

Assistant House Surgeons

To:

Mr. Lawrie — Mr. M. S. Vernon
Appointed for 6 months, the first 3 as A.H.S.

Mr. Glover — Mr. P. A. D. Williams
Appointed for 6 months, the first 3 as A.H.S.

Mr. Brain — Mr. J. D. Rogers
Appointed for 6 months, the first 3 as A.H.S.

Mr. Beard — Mr. B. S. Ricketts
Appointed for 6 months, the first 3 as A.H.S.

Assistant House Physicians

To:

Dr. Mann, Dr. Scott and Dr. Bishop — Mr. W. T. Lamb
Appointed for 6 months, the first 3 as A.H.P.

Dr. Hardwick, Dr. Trounce and Dr. Deuchar — Mr. D. G. Gourley
Appointed for 6 months, the first 3 as A.H.P.

Dr. Baker, Dr. Houston and Dr. Grimble — Mr. C. E. Lamb
Appointed for 6 months, the first 3 as A.H.P.

Dr. Kauntze and Dr. Joiner — Mr. T. N. D. Peet
Appointed for 6 months, the first 3 as A.H.P.

Professor Butterfield, Dr. MacLean — Mr. N. W. D. Walshaw
3 months

Casualty Officers

Mr. D. R. Bevan
Mr. T. J. R. Bruce
Miss E. A. Cosgrove
Mr. A. M. Morris
Mr. G. A. Pettitt
Mr. A. R. M. Upton
3 months

House Surgeon to the Surgical Unit

Miss C. J. S. Lawrie
6 months

House Surgeons

To:

Mr. Eckhoff — Mr. C. G. C. Gaches
6 months

Professor Atkins — Mr. T. M. Jenkinson
3 months

Mr. Wass — Mr. P. D. Davies
6 months

Mr. Blackburn — Mr. M. W. J. Older
3 months

House Physicians

Dr. Mann, Dr. Scott and Dr. Bishop — Mr. B. H. Hicks
6 months

Dr. Hardwick, Dr. Trounce and Dr. Deuchar — Miss J. P. Pearse
6 months

Dr. Baker, Dr. Houston and Dr. Grimble — Mr. A. L. W. F. Eddleston
3 months

Dr. Kauntze and Dr. Joiner — Mr. R. A. Y. Pietroni
3 months

Professor Butterfield and Dr. MacLean — Mr. M. B. Barnett
6 *months*

Resident Obstetricians
Mr. D. J. Simler
3 *months*
Mr. V. E. Egwuatu
6 *months*

Gynaecological House Surgeon
Mr. J. B. M. Shepherd
3 *months*

Throat and Ear House Surgeons
Mr. C. R. Sheard
3 *months*
Miss J. R. Townsend
6 *months*

Orthopaedic House Surgeons
Mr. A. M. Roberts
6 *months*
Mr. J. S. Gregson
6 *months*

Dermatological House Physician
1.8.65—31.1.66 — Miss E. Sherbel
1.2.66—31.7.66 — Readvertised

Neurological House Physician
Mr. C. P. W. Warren
3 *months*

Genito-Urinary House Surgeon
Mr. P. J. C. Baxter
6 *months*

House Surgeons to the Thoracic Unit
Mr. R. J. Parker (S.H.O.)
3 *months*
Mr. T. C. Davis
6 *months*

Children's House Physicians
Mr. G. Hambleton
3 *months*
Miss J. A. Chown
6 *months*

House Physicians in Clinical Pathology
Mr. J. Burke
3 *months*
Mr. A. J. Knell
6 *months*

House Physician to Dr. Bishop, Dr. Wayte and Mr. McArthur
Mr. G. Llewellin
3 *months*

House Physician in Child Psychiatry
Readvertised

House Physicians in the Department of Psychological Medicine
1.10.65—31.3.66 — Mr. P. Nott
1.10.65—31.3.66 — Mr. K. F. Standage

R.M.Os. in Nuffield House
1. 9.65—28.2.66 — Mr. P. G. Pletka
1. 1.66—30.6.66 — Mr. J. D. Steele-Perkins

Resident Anaesthetists
1. 9.65—28.2.66 — Mr. R. K. R. Innes (S.H.O.)
1. 9.65—28.2.66 — Mr. T. E. J. Healey
1.12.65—31.5.66 — Mr. D. G. Nancekievill (S.H.O.)
1.12.65—31.5.66 — Mr. B. R. T. Smith

Children's House Physician at the Evelina Hospital
1. 2.66—31.7.66 — Mr. B. G. R. Neville

Casualty Officer (part-time) at the Evelina Hospital
Readvertised

ST. OLAVE'S HOSPITAL
House Physicians to Dr. Mason and Dr. Cox:
Mr. A. W. J. Medhurst
Mr. I. A. Sutherland

House Surgeon to Mr. O'Flynn:
Mr. A. H. Mowbray

House Surgeon to Mr. Lewys Lloyd:

Gynaecological House Surgeon

Casualty Officer

NEW CROSS HOSPITAL
House Physicians in Medicine and Geriatrics:
Mr. A. D. Milner (S.H.O.)
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House Surgeon with Ophthalmology:
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PEMBURY HOSPITAL
House Surgeons:
Mr. G. F. Wearne
Mr. L. G. Parry

House Surgeon with Orthopaedics:
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House Surgeon with Orthopaedics (S.H.O.):
Readvertised

QUEEN MARY'S HOSPITAL, SIDCUP
House Surgeons:
2 vacancies readvertised

House Physician:
Mr. R. E. Dzievanowski

ST. JOHN'S HOSPITAL, LEWISHAM
House Surgeon with Gynaecology:
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House Surgeon with Gynaecology and Orthopaedics:
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P. J. HELLIWELL,
Acting Superintendent.

November 19th, 1965.

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The Chartered Society of Physiotherapy Examinations

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Cook, M. T.
Harper, B.
Lawson, A. H.
Foote, C. D.
Mann, B. H.
Scott, N. C.
Seymour, S. J.
Smith, C. A.
White, C. M.
Young, M. P.

PERSONAL

If there is a Dental Surgeon wanting a position as assistant, an all-Guy's practice in the West End (principal and two assistants) looking for a successor for one of the leaving assistants, would welcome a call, WELBECK 9433, or Box No. 50. Five-day week, 9.30—6 p.m.

WANTED—Pre-war Guy's Hospital blazer buttons, small and large size. Etheridge, 73, Fitzjohn's Avenue, Hampstead, N.W.3.

Modern two-bedroomed flat, S.E.1., six year lease. Married couple or single person. HOP 5903.

CHANGES OF ADDRESS

DUFF.—John and Julia Duff, to Queen Elizabeth Hospital, Bridgetown, Barbados, W.I.

STRUTT.—Bishop and Mrs. Gordon Strutt, to Bishop's Lodge, Alderley Edge, Cheshire. Telephone: Alderley Edge 2074.

BIRTHS

ADAMS.—On September 30th, to Jamie and Dawn Adams, a son, Justin Peter, a brother for Stephen, Matthew and Lucy. 26, Morrend Road, Leckhampton, Cheltenham, Glos.

BENITZ.—A son, Gregory Arthur, to Patricia (née Jewell) S.R.N., and Phillip Benitz, at Route 3, Wathena, Kansas, U.S.A.

FORSYTHE.—To Malcolm and Delia (née Moore) on 30th September, 1965, at Farnborough Hospital, Kent, a son Marcus.

GARDNER.—On October 19th, to Juliet and Nigel Gardner, a son, James Nigel, a brother for Nicola.

HORSFALL.—To Dick and Nancy (née Hudson) S.R.N., a daughter, Nancy Claire, a sister for Jane, Paul and Martin, on September 7th, at Witbank, South Africa.

TOMLINSON.—On November 1st, to Patricia (née Lane) M.B., B.S., and John Tomlinson, M.B., B.S., a son, David Guy, a brother for Charlotte. 23, Carrick Road, Curzon Park, Chester.

EDITORS A. E. RAYNES and M. F. D'SOUZA
SPORTS CORRESPONDENT D. J. HENDRICK
FORTNIGHTLY TWO SHILLINGS VOLUME 79 NUMBER 2018

PASSIM

The Bloomfield Clinic

A public institution can pride itself when, in the age of the Welfare State, it can still attract benefactors to provide amenities not made available by the State. During the two hundred and forty years since the will of the hospital's original benefactor, which stated, "And my mind and will is . . . that they receive and entertain Lunatics, adjudged or called, as aforesaid Incurable, not exceeding Twenty in number at one time", the number of public psychiatric beds has only increased by three. It is perhaps appropriate that a donation has been given to further the amenities provided by Guy's for its psychiatric patients.

Guy's is grateful for the generosity of Mr. Bloomfield, who has provided the hospital with a new Child Psychiatry out-patients' building, and to Mr. Marchant, who provided its internal television and recording apparatus, and to British Relay who installed it.

The Bloomfield Clinic is a two-storey building containing six clinical rooms, a library, two television recording rooms and a teaching room. The internal television equipment will enable parents and children to be interviewed away from the restricting influences of a student audience. There is something particularly unsympathetic in expecting patients to speak freely about their personal problems, problems which have motivated them to seek professional help, in front of audiences of ten to twenty people. With the interview in this more private and personal setting and the use of television equipment, the student can hope to gain a more realistic and extensive picture of psychotherapy. The recording apparatus will enable films to be made directly from the televised interviews.

The building will not be restricted solely to child psychiatry and its use is to be flexible to some extent. Physiology tutorial groups have already been meeting in the Bloomfield Clinic and perhaps this may set a precedent for the better co-operation between departments and the sharing of facilities to relieve the unnecessary congestion caused to some extent by departmental isolation.

The future comprehensive development scheme for Guy's has limited the planning of the new clinic to a temporary basis, and its expected life can only be about ten or fifteen years. It is hoped that in the final plans for Guy's, provision will be made for the perpetuation of a Bloomfield Clinic.

Patient Permission

"Languid I lay and thou camest, O Symmachus, quickly to see me.
Quickly thou camest and with thee a hundred medical students.
The hundred pawed me all over with hands congealed by the north wind.
Ague before I had none, but now, by Apollo, I have it."

This epigram, by Martial, is perhaps not entirely true today, but the message still sounds familiar. The modern Symmachus may not arrive so quickly but his students will almost certainly be numerous and many will have very cold hands. The patient who complains bitterly about this, however, is not at all popular in to-day's Teaching Hospitals, for without clinical material medical training would lose its most valuable ally. But occasionally there is ample justice for complaint, but of this, the Symmachus concerned must be the arbiter, for he alone can change the situation.

Most of these complaints stem from a natural embarrassment that has been given voice either by a neurotic disposition or by some failure in the doctor-patient relationship: often this cannot be helped and is best accepted as being unfortunate and left at that. On some occasions, however, when this has occurred and patients have refused to permit students to examine them, the consultant has countered by refusing to examine them himself, saying that since they have come to a teaching hospital they should expect to be seen by students. The patient, however, may justly quarrel with such a pronouncement since to receive an examination by students was by no means the purpose of their visit and more often than not it was their doctor rather than they themselves who decided that they should come to the hospital in the first place, too often without explaining that they would probably be seen by students. This is a valid argument and it is certainly the practice on the wards and in most of the out-patient departments to ask patients out of common courtesy whether they would mind medical students examining them. However, to presume that they must say "Yes" or suffer the consequences of not being seen by the consultant is to make a mockery of the request and would seem to be pressing the privilege of medical education too far.

There is an ample number of patients who readily submit to student examination often with remarks like: "I suppose you've got to learn sometime." There are also many who welcome the added attention that students give them. The important point is, however, that these men and women are voluntarily doing the profession a favour, for which we should be very grateful. And if all general practitioners who sent patients to teaching hospital consultants previously explained to them that they may be seen by students as well, these rare occasions of disagreement could probably be avoided.

Dr. H. W. Levitt has been elected Chairman of the Council of The College of General Practitioners for the second year in succession. The College has awarded the Butterworth Gold Medal to Dr. F. P. Walt and the Upjohn Award to Dr. M. L. Walt.

Dr. Robert Mahler has been appointed Professor of the new Department of Clinical Chemistry at the Welsh National School of Medicine in Cardiff.

The next edition of the Gazette will be the Christmas Edition and will be issued on December 23rd. Because of this earlier publication date the last date for contributions will be Thursday, December 16th.

GUY'S DIARY

DECEMBER

Exhibition.			The Acute Abdomen.
13th	M.	1.00	Clinical Lecture. Dr. DEUCHAR. "Living with Heart Disease".
		4.30	Lecture. Dr. MURRAY FALCONER. "Memory Recording Mechanisms in the Cerebral Hemisphere".
14th	Tu.	1.00	Clinical Lecture. Mr. READING. "Pain in the Ear".
		4.30	"Tutorials for Clinical Students". Students' Education Committee Discussion in Anatomy Theatre.
16th	Th.	1.00	Clinical Lecture. Mr. HUDSON. "Ocular Pain".
17th	Fr.	1.00	Clinical Lecture. Professor BUTTERFIELD. "Cardiac Arrest".
31st	Fr.	1.00	Clinical Lecture. Mr. R. H. F. BRAIN.

THE DOWAGER LADY EBBISHAM, M.B.E.

All those who have been connected with Guy's over the years will have been honoured to know Lady Ebbisham. They will remember her with affection and be saddened by her passing.

Those who have been privileged to work with her were conscious of her deep concern for all that affected Guy's, its patients and staff, and her devotion to the best interests of the Hospital.

Lady Ebbisham was an Honorary Member of the Guy's Hospital Past and Present Nurses' League for many years but perhaps the work which took up most of her time was the Guy's Hospital Ladies' Association of which she had been Chairman since 1934. She has always taken the greatest interest in its work and aims and even up to a few days before her death she took part in all its activities.

Whenever one met Lady Ebbisham at committees and social functions in the Hospital, in her own home or at the Mansion House, she was the same serene, gracious lady and our sympathy goes out to her family in their great loss.

D.M.S.

Time Table of Events at Guy's Christmas, 1965

MONDAY, DECEMBER 13TH,	
7.30 p.m.	Students' Christian Union Carol Service in the Hospital Chapel.
TUESDAY, DECEMBER 21ST,	
8.45 p.m.	Service of Carols and Nine Lessons in the Hospital Chapel.
WEDNESDAY, DECEMBER 22ND,	
4 p.m.	Dressers' Teas and Ward Decorations (Children's Wards only).
6—7.30 p.m.	Carols by The Southwark Cathedral Choir.
	Party "A": Hunt's House, Nuffield House and York Clinic.
	Party "B": New Guy's House.
THURSDAY, DECEMBER 23RD,	
4 p.m.	Dressers' Teas and Ward Decorations.
FRIDAY, DECEMBER 24TH, *Christmas Eve.*	
4 p.m.	Dressers' Teas and Ward Decorations.
11.30 p.m.	Midnight Eucharist in the Hospital Chapel.
SATURDAY, DECEMBER 25TH, *Christmas Day.*	
6—7 a.m.	Nurses' Carols in the Wards.
8.20 a.m.	Holy Communion, Hospital Chapel.
7.30—8 a.m.	Nurses' Breakfast in the Nurses' Home.
10.30—11 a.m.	Morning Service, Hospital Chapel.
12 mid-day.	Patients' Christmas Dinner.
1—2 p.m.	Resident Domestic Staff Dinner in Tabard House.
1 p.m.	Nursing Staff Christmas Dinner in Wards.
3.30—4.30 p.m.	Patients' and Staff Tea in Wards.
7.30—8.30 p.m.	Nurses' Supper in the Wards at the Sisters' discretion.
	All Day Nurses to be off duty and out of the Wards by 8.45 p.m.
9 p.m.	The " Christmas Show " by the Students in the Physiology Theatre.
SUNDAY, DECEMBER 26TH,	
6 a.m.	Patients' Communion in the Wards.
7 and 8.20 a.m.	Holy Communion, Hospital Chapel.
10.45 a.m.	Morning Service, Hospital Chapel.
2—4 p.m.	Visitors' Teas in the Wards.
MONDAY, DECEMBER 27TH, *Boxing Day.*	
6 p.m.	"Christmas Show"' by the students in the Physiology Theatre.
1966.	
THURSDAY, JANUARY 6TH,	
7 p.m. for 7.30 p.m.	Sisters' Dinner in the Nurses' Dining Room.
THURSDAY, JANUARY 13TH,	
7 p.m. for 7.30 p.m.	Staff Nurses' and Staff Midwives' Dinner in the Nurses' Dining Room.

Burns in Childhood

by D. J. Richards

The Size of the Problem

Over 100,000 people are burnt or scalded in England and Wales each year and require hospital treatment. Of these about 10,000 require admissions to hospital, where the average stay is six weeks. About 700 people die annually in England and Wales from thermal injuries—at least 25 per cent of these are children.

In a recent survey of burns in children—scalds accounted for 41 per cent, burns due to clothing catching fire 28 per cent, burns due to contact with hot objects 17 per cent, electric fire burns 9 per cent, flash burns 4 per cent, and chemical burns 1 per cent (Muir and Barclay 1962).

The commonest type of injury in the infant is a scald of the buttock. During the second year of life, scalds of the face, neck, chest and shoulders are common. These are often seen in the inquisitive male toddler who pulls cups, saucepans, etc., over himself. These scalds are, fortunately, relatively superficial in most cases. Deep burns of the hands, due to contact with the elements of electric fires are seen in children under 4 years of age. Once again, the inquisitive male child is the victim. The most lethal burns of childhood are seen in the 3—4 age-group. This is well illustrated by the case of the girl whose nightdress accidentally catches fire. These patients usually sustain deep and extensive burns of the thighs and trunk.

A recent analysis of 600 cases of burnt children admitted to the Children's Burns Unit at Guy's Hospital shows that scalds outnumbered burns overall by 3 : 2. If cases of thermal injury of over 15 per cent body surface are considered, burns outnumber scalds by over 3 : 1.

An analysis of the mortality shows that less than 1 per cent of scalded children die—whereas with flame burns the mortality is of the order of 10 per cent. In cases of conflagrations in confined spaces the mortality reaches 30 per cent (Clarkson, 1963).

Prevention

Several years ago, Colebrooke worked out that well over half of all burns and scalds incurred in the home could be avoided (Colebrooke, 1949).

In children, this percentage is probably much higher. Careful discipline in the home is essential. Children are very enquiring and mothers and guardians must take great care to insure that children are well protected from open coal fires and that the handles of saucepans are turned inwards on the stove. In recent years, legislation has demanded that only guarded electric fires should be sold. Paraffin stoves should conform to the requirements laid down in the Oil Burners (Standards) Act of 1960. From 1961, attempts have been made to market improved flame resistant fabrics and garments, but nevertheless, many highly inflammable articles of children's clothing can be bought in shops and on market stalls. Certain difficulties are encountered in attempting to sell the flame resistant clothes. Firstly—

as a result of treatments to the material—the end-product is more expensive than the comparable garment made of untreated fabric. Secondly, it should be remembered that many of these fabrics do not remain flame resistant after several washings and they may well be dangerous in that the parents are lulled into a state of false security.

Over the last few years there has been a great change in social habits. Gas fires and electric heaters have tended to replace the open coal fire and there has been a trend towards the use of central heating. However, the paraffin stove still remains the cheapest form of heating and this method is used extensively by the coloured immigrants. There is a high incidence of thermal injuries to coloured children and a recent survey of the 1964 admissions to the Children's Burns Unit, Guy's Hospital, has shown that 1 child in 4 was coloured. This incidence is totally out of proportion to the number of immigrants in the local population. The main reasons for this high incidence are overcrowding and the use of paraffin stoves as a method of heating.

First Aid Treatment

In scalds, the hot, wet clothing should be removed instantly, because the longer the period of contact, the greater the chance of a deeper skin lesion.

In burns, the flaming clothing must be extinguished. A man can roll on the burning child with relative safety but a woman should not do this as there is a risk that her own clothes may easily catch fire. Thus the child should be rolled up in a blanket or a rug, if one can be found soon enough. The burnt clothing should then be removed as expeditiously as possible because it retains heat and this may well cause further skin damage.

Management of the Severely Burnt Child

It is recommended that all burnt children should, if possible, be transferred early on to the nearest special centre. Prior to transit, however, the intravenous life-line should be established, sedation must be given and the patient must be assessed as to whether or not a tracheostomy is necessary to counteract any possibility of airway obstruction during the transfer. In cases admitted direct to the Burns Unit it is a good rule of thumb that the intravenous life-line be established within a quarter of an hour of the child reaching the unit. Many of the intravenous drips impose serious technical difficulties and much valuable time may be lost unless there is such a clearly set out timetable to be followed.

The severity of the injury will depend upon the extent of the burn, its depth and also the presence or absence of associated deep damage especially to the respiratory system. Other factors of importance in this respect are the age and general condition of the child.

(a) Estimation of Percentage of Body Surface Burnt

In adults this can rapidly be carried out by the application of the Rule of Nines. However, in children this does not apply as there is a disproportionate size of head, thighs and legs in the child when compared with the adult. Thus, it becomes necessary to resort to the use of specially constructed tables in order to arrive at an accurate estimate of the size of the burnt area.

(b) Estimation of Depth

It is necessary to distinguish between partial skin loss and whole skin loss. In the former group, if infection can be prevented, spontaneous healing will occur and skin grafting will not be necessary. However, infection can readily convert a deep, partial thickness burn into one of full thickness loss.

Whole thickness burns will not heal spontaneously and an open wound is present. Thus the burn wound must be closed and this closure is brought about by skin grafting at a time when the recipient surface is in a suitable condition to accept the graft. This is done about the end of the second week or at the latest by the end of the third week after the burn.

On the whole with scalds—if the clothing is removed rapidly—the skin involvement is likely to be superficial. Flame burns, that is those caused by the contact of the thin skin of the child with burning clothing, and electrical burns on the other hand are usually deep and involve whole thickness skin loss.

(c) Treatment of Shock

The extensively burnt child is a severely shocked child.

Primary shock occurs early on and passes off spontaneously. This is the neurogenic type of shock which is associated with painful stimuli. Secondary shock comes on rather later, but always within the first few hours after the burn. The latent period before the onset of the symptoms of this secondary shock may be shorter in the child than in the adult—that is it may be present within one hour—rather than in six to eight hours. This is an oligaemic type of shock and is due to the outpouring of fluid from the circulation into the burnt tissues. This fluid closely resembles plasma in both its protein content and electrolyte composition. Unless this fluid loss is counteracted at an early stage, the shock may rapidly become irreversible. The loss of plasma-like fluid from the circulation occurs at a high rate during the first 12 hours after burning, but the rate of loss falls off so that at the end of 48 hours it is minimal. It is imperative that this fluid loss should be counteracted early on in order to prevent the onset of oligaemic shock. In burns of over 10—15 per cent surface in children the loss must be made up by the giving of intravenous fluids.

Various formulae have been devised in order to calculate the amount and type of intravenous fluid to be given. These formulae are valuable as guide-line but should not be too rigidly adhered to. The clinical condition of the patient is the all-important factor and the amount and type of fluid given should be modified accordingly. This is the method of "Continuous Clinical Control" initially advocated by Bull. The amount of fluid for the individual case is determined by the urinary output, the systolic blood pressure and the clinical state of the patient. The use of an intravenous pressure measurement device is probably the most delicate monitor and its use is justifiable in the most severe and extensive cases, especially those having an early excision of the burnt tissue.

The policy of the Children's Burns Unit, Guy's Hospital, with regard to intravenous replacement therapy is to replace 10—15 per

cent of the child's body weight in the first 48 hours after the burn. If the child is unable to tolerate the oral fluid of ordinary maintenance therapy—this volume of fluid must also be given by the intravenous route. The amount and type of fluid required for maintenance is calculated with reference to the child's body-weight and this is given in the form of an electrolyte solution.

The amount and type of fluid given for replacement therapy will depend upon the extent and depth of the burn. The volume of fluid required over the first 48-hour period is calculated with reference to the child's weight and the volume is given as equal parts of colloid and of electrolyte. The colloid is usually given in the form of Dextraven or Rheomacrodex. In deep burns about one-third of the colloid requirement should be given in the form of whole blood.

In view of the early rapid loss of fluid from the burnt surface, more fluid should be given early than over a similiar period later. Thus the total volume of intravenous fluid for both maintenance and replacement therapy over the 48-hour period is calculated and this is then given in three equal amounts over the periods 0—8 hours, 8—24 hours and 24—48 hours.

Having established the intravenous life-line, sedated the child and calculated the fluid requirements, it is of value to plot graphically the clinical, haematological and biochemical progress of the patient. The pulse rate, blood pressure, urine output and body-weight in kilograms are recorded. At the same time regular estimation of haemoglobin and packed cell volume are made and recorded. It is also of value to have daily blood electrolyte estimates. More recently, measurement of skin temperatures and venous pressures have been found to be of extreme value in monitoring the progress of the severely burnt child.

(d) Care of the Burnt Surface

Primary toilet of the burnt surface is carried out once measures have been taken to deal with shock. This procedure may take several hours and is best carried out by experienced nursing staff and is performed under adequate heroin analgesia.

There are many different methods advocated for the treatment of the burnt surface. In principle, they should be aimed at the prevention of infection in partial thickness burns. In deep burns these methods should be aimed at removal of the dead tissue as soon as possible and then the next object should be the closing of the burn wound.

Initially, the burnt surface is relatively sterile but it does not remain in this state for very long. The burnt tissue is an excellent pabulum for bacterial growth. Bacteria will soon invade the burn would and will produce their harmful effects both locally and generally.

Nowadays, as a result of a clearer understanding of the pathology and management of shock, infection is the commonest cause of death following thermal injury. Staphylococcus Aureus and Pseudomonas Pyocyaneus are the two organisms which most commonly infect burnt tissue. Occasionally the infecting organism may be Proteus Vulgaris, Haemolytic Streptococcus or Clostridium Tetani.

Infection can produce its harmful effect in many ways. It may readily convert a deep partial thickness burn into one of full thickness loss, it may delay the healing of the burnt surface, it may cause the loss of skin grafts or it may cause a rapidly fatal septicaemia.

Essentially, the burnt surface may be treated by one of two methods, i.e., exposure or dressings. The exposure method aims at allowing a crust to develop over the burnt surface. This crust will act like a dressing and protect the burnt area from bacterial invasion. This crust will begin to separate spontaneously after two or three weeks, this separation being accelerated by soaking the burnt surface with wet pads and later by immersion of the child in a bath. If the burn is one of partial thickness, a healing surface will be left when the crust is removed. If the burn is of full thickness a granulating surface will be exposed on removal of the crust. If the granulations appear healthy and this can be confirmed by culture, the surface can then be covered with skin grafts. If the granulations are obviously unhealthy and infected, further local treatment will be necessary before skin grafting can be attempted.

Partial thickness autografts are used to cover the raw area. These grafts are usually taken from the posterior aspect of the upper thigh, which is the donor site of choice in modern plastic surgery.

Occasionally, in very extensive burns, it may be necessary to resort to the use of homografts taken from a close relative of the burnt patient. This type of skin graft will not take permanently, but in these cases it acts as a suitable cover while the other donor sites are recovering.

Skin grafts are cut with a Humby knife or dermatome. The raw area can be covered either by using sheets of graft or by using small grafts cut to the size of a postage stamp. The former method of skin cover will produce a more acceptable cosmetic appearance but in extensive burns this method of cover will not be possible because of the shortage of donor skin.

The aim of treatment must be to terminate the burn illness as quickly as possible. This can only be said to have been achieved when the burn wound has been closed—that is the burnt surface has been completely covered with skin grafts.

In severely burned children, some later plastic surgery is nearly always necessary. Many of these unfortunate individuals will spend many months or even years in hospital having various reconstructive procedures performed. In many cases, especially those requiring facial reconstructions, it is preferable to delay this until the age of 12 to 15 years.

Most of these children become severely upset from a mental health point of view and will require careful and sympathetic handling at all stages.

I wish to acknowledge the help, encouragement and advice given by Mr. Patrick Clarkson, Plastic Surgeon to the Accident Service.

References to this article appear on page 609.

Malignant Disease in Childhood

by John Martin

Malignant disease has become an increasingly important aspect of paediatrics in recent years as other problems such as the acute infections have been largely overcome. Although the average medical practitioner in Britain rarely sees a child with malignant disease it is now the third commonest cause of death in children over the age of one year.

Main Causes of Death in Children 1—15 years.
England and Wales, 1962. (Registrar-General's Report)

All accidents	1403
Motor vehicle accidents ...	637
Respiratory diseases	854
Malignant disease	766
Congenital malformations ...	578
Gastroenteritis	137
Meningitis	112

Malignancies that commonly occur in children differ markedly from those most frequently seen in adults; the leukaemias, tumours of the nervous system and of connective tissues predominating in childhood and epithelial tumours in adult life. The relative frequencies of childhood tumours are illustrated in the following table which analyses 998 cases included in the Manchester University Children's Register in a ten-year period between September 1953 and September 1963.

Manchester Children's Tumour Register
Types of Tumours
September 1953—September 1963

Reticuloendothelial tumours		373
Leukaemia ...	289	
Non-leukaemic ...	84	
Nervous system tumours ...		276
Gliomas	170	
Tumours of sympathetic nervous system ...	75	
Retinoblastomas ...	31	
Connective tissue tumours ...		115
Wilm's Tumours		54
Teratomas		44
Epithelial Tumours		38
Ewing's Tumours		22
Others		76
		998

All of these cases came from the Manchester Hospital region, and were under fifteen years of age when diagnosed. It can be calculated that from the one million children in the Manchester Hospital region approximately one hundred develop some form of neoplastic disease each year. The majority but not all of these cases are malignant.

Some features of each of the main groups of tumours will be outlined.

Leukaemia—is the commonest form of malignant disease in childhood (28.9 per cent of cases in the Manchester Children's Tumour Register) and is almost always of the acute variety. Chronic myeloid leukaemia occurs occasionally in childhood but not chronic lymphatic leukaemia. It is more frequent in males than females, there are no racial or geographic factors in its aetiology, but there is a high incidence in mongolism. The disease is more common under the age of five years and there is a slight secondary peak at eight to nine years of age. A leucopenia is present in the majority of children, a leucocytosis is less common and is associated with a lower remission rate on treatment.

During the last twenty years, considerable advances have been made in the treatment of acute leukaemia. The introduction of folic acid antagonists, steroids, purine analogues and more recently cyclophosphamide and vincristine, together with the judicious use of transfusions and antibiotics, has extended the average duration of life after diagnosis from four to thirteen months. Perhaps of more importance is the fact that an increasing number of patients are surviving two or more years. Recently Burchenal (1964) has collected over one hundred children from centres all over the world who have survived five years from diagnosis. None of these children who survived eight years has subsequently died.

The longer survival of children has lead to meningeal leukaemia being seen with increasing frequency. This may occur whilst the child is in haematological and bone marrow remission and usually responds well to intra-thecal methotrexate.

Non-Leukaemic Reticuloendothelial System Tumours — the most common tumours in this group are lymphosarcoma, reticulosarcoma and Hodgkin's disease all of which occur more commonly in boys than girls approximately in the ratio of two or three to one. Lymphosarcoma and reticulosarcoma appear most commonly between the age of three and seven years. Several cases of congenital lymphosarcoma have been described. In children the small intestine, mediastinum and nasopharynx are clinically important sites of primary lymphosarcoma. A multicentric anaplastic lymphosarcoma of the jaws—Burkitt's tumour—is one of the commonest tumours seen in African children in Uganda, and ovarian tumours are a common feature of lymphosarcomatosis in young African girls in Nigeria. The majority of children with lymphosarcoma or reticulosarcoma succumb within two years, many from supervening leukaemia. Treatment consists of surgery, radiotherapy or chemotherapy, or a combination of these.

Hodgkin's disease is very rare in infants and children under two years but may occur at any later age. Histologically the disease shows a wide variation from patient to patient and even from site to site in the same patient. Similarly the length of survival varies from a few months to thirty-three years (Pitock et al., 1959). Radiotherapy with or without chemotherapy is the usual treatment, but if the affected nodes are localised to the cervical region radical surgical excision may lead to a cure.

Gliomas—account for 15—20 per cent of registered deaths from tumours in childhood. The great majority of these tumours are either medulloblastomas or astrocytomas. Early childhood is one of two peaks in the incidence of gliomas, the other being in the fifth decade. Medulloblastomas occur about two or three times as often in boys as in girls, but there is little, if any, difference in sex incidence in other types of glioma. Three-quarters of the gliomas of childhood are sub-tentorial in contrast to adults.

Medulloblastomas have their peak incidence at five years of age. They are clearly embryonic in origin and many show partial differentiation in the form of recognisably astrocytic or oligodendroglial areas. They frequently infiltrate the basal meninges and disseminate via the cerebro-spinal fluid to produce metastases in other parts of the central nervous system, especially the spinal theca. Remote metastasis is very rare. Medulloblastomas are very radiosensitive but are seldom cured.

The majority of astrocytomas are cerebellar and fall into two groups. The larger group consists of well circumscribed, highly differentiated, often cystic tumours that are slow growing and whose complete removal is curative. Tumours of the smaller group, though they may show varying degrees of differentiation, are ill-defined, invasive and their complete removal is not possible. Other sites of astrocytomas in childhood are the brain-stem, hypothalamus, optic nerves and rarely the cerebrum and spinal cord.

Ependymomas arise most often from the fourth ventricle, are radiosensitive and have occasionally been cured. Pure oligodendrogliomas are rare in childhood though oligodendroglial differentiation is seen both in medulloblastomas and in some predominantly astrocytic gliomas.

Tumours of the Sympathetic Nervous System—are the third commonest group of tumours in childhood. The majority are derived from non-chromaffin tissues and range from the malignant neuroblastoma consisting of immature nerve cells to the ganglioneuroma, a benign fully differentiated tumour composed of nerve cells and fibres. Tumours originating from the chromaffin tissues are the functioning phaeochromocytoma and the non-functioning paraganglioma.

Neuroblastomas occur predominantly in infancy or early childhood. There is no definite sex incidence. Fifty per cent of cases arise from the adrenal glands or neighbouring sympathetic ganglia and the remainder from the cervical, thoracic or lower abdominal sympathetic chains. These tumours often show calcification and may be accompanied by excessive secretion of the breakdown products of adrenaline and noradrenaline which can be chemically estimated in the urine as 4-hydroxy-3-methoxy mandelic acid (HMMA also known as VMA). Neuroblastomas disseminate widely to lymph nodes, and via the blood stream especially to the liver and bones. Gross hepatic enlargement due to metastases constitutes Pepper's syndrome. This occurs especially in infancy and in some cases is present at birth, metastasis having clearly taken place in foetal life. Bony metastases are frequently widespread and when prominent in the skull form Hutchison's syndrome.

The histological structure of neuroblastomas varies widely from the completely undifferentiated tumour to that in which young nerve cells and fibres are recognisable. Several cases have been recorded where an actively growing neuroblastoma has undergone complete maturation to a ganglioneuroma. This process may be responsible for some of the spontaneous cures reported.

Treatment consists of surgical excision where possible. Radiotherapy and chemotherapy can be used in conjunction with surgery or alone if surgical removal is not possible. Vitamin B12 was reported by Bodian and White to be of value but this has not been substantiated by other workers. The prognosis for children under one year, with or without hepatic secondaries, is quite good, whilst in older children or in the presence of bone secondaries it is very poor.

Retinoblastomas—are intra-ocular neural tumours. They occur in both sexes equally, predominantly before the age of three years, and in 25 per cent of cases are bilateral. The majority of cases are sporadic but there are many striking examples of a familial or hereditary incidence. Transmission in such families is dominant but the affected gene may be passed on by a seemingly healthy person. The principal route of extra-ocular extension is via the optic nerve to the cranial cavity. Remote metastases are infrequent. Treatment is by enucleation of the eye and as much of the optic nerve as possible. Where both eyes are affected radiotherapy is the treatment of choice.

Connective Tissue Tumours—are relatively common in childhood and account for one in eight of cases notified to the Manchester Children's Tumour Register. About 60 per cent of these tumours are malignant. Striped muscle is particularly liable to undergo malignant change in childhood and rhabdomyosarcomas are seen especially in the ear, orbit, face and urogenital tract. Other connective tissue tumours such as osteogenic sarcoma, chondrosarcoma and meningioma occur in older children and differ little from those seen in adults. Prognosis of these tumours depend on their malignancy and the feasibility of their complete surgical removal.

Wilm's Tumour—or nephroblastoma is an embryonic renal tumour. Most of these tumours present in infancy or early childhood, and rare cases are seen at birth. They are usually single, unilateral and do not extend across the mid-line but bilateral cases have been reported. Wilm's tumour remains encapsulated for some time and then invades pelvis, ureter and renal veins. Blood stream spread leads to lung metastases, or less frequently to metastases in liver, bone or other organs.

For many years treatment consisted of urgent surgical removal after a minimum of handling followed by radiotherapy. Recently, a toxic antibiotic actinomycin D has been found to have a selective effect on Wilm's tumours. Operation is now being performed under cover with actinomycin D which is continued in the post-operative period. Irradiation is given later when the bone marrow has recovered from any depression due to the drug, and the wound has healed. This form of therapy has produced some very encouraging results (Howard 1965).

Teratomas—are tumours that arise from immature tissues during development. Actively growing teratomas produce a variety of tissues foreign to the site in which they grow. They occur most commonly in childhood in the ovary, testis, and sacrococcygeal region. Teratomas of the ovary and testis presenting in childhood are usually benign in contrast to those first seen in adults which are usually malignant. Sacrococcygeal teratomas with rare exceptions are present at birth and occur three or four times as commonly in females as in males. They are almost always benign and can be cured by surgical removal. Cranial, cervical, intrathoracic and retroperitoneal teratomas also occur in children.

Epithelial Tumours—in contrast to adults, these are rare in children. They mainly appear in older children and behave in a similar fashion to the corresponding adult tumours. Except for certain children with an inherited predisposition to a particular type of tumour, e.g., polypopis coli, they are probably due to the same carcinogens as cause adult tumours.

Ewings Tumours—are non-osteogenic malignant neoplasms of bone. There is some doubt as to whether Ewing's tumour is a pathological entity. Many believe it is a clinical syndrome of a non-osteogenic, round cell, radiosensitive tumour of bone, usually a long bone of a young child, that leads to diffuse elevation and osteogenic activity of the periosteum. The commonest cause of this syndrome is probably a metastatic neuroblastoma. Reticulum cell sarcoma of bone may produce this picture but whether any other primary tumour of bone is capable of producing it is very doubtful.

Among the miscellaneous group reported to the Manchester Children's Tumour Register are *hepatoblastomas*, *pinealomas* and malignant melanomas.

The above information is of necessity sketchy and some points may be controversial. It was intended only to outline the subject and highlight certain aspects.

The overall prognosis of childhood malignancies is still very poor. Advances in the future will depend on earlier diagnosis and skilful therapy with a combination of surgery, radiotherapy and chemotherapy. Therapeutic advances are difficult to assess because, although the total number of cases is large, the number treated in any one centre is usually too small to run any kind of controlled trial. There is much to be said for compulsory notification on diagnosis of children's tumours and for treating them at a few large centres. This may lead not only to better therapy, but by carefully taken histories, examination, and investigation, common factors may emerge and throw some light on to their aetiology.

I am grateful to Dr. J. K. Steward, lecturer in charge of the Children's Tumour Register of the University of Manchester, for permission to use figures from the register.

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The Waters of Babylon

by John Arden

— *A CRITICISM*

John Arden may be the best English playwright at the present time, and might be much more; he is certainly one of the most original writers for the stage we have had for a long time. His plays always stimulate as well as entertain, and he has persistently written drama which cuts across the current ephemeral fashions of the theatre. "The Waters of Babylon" was only his second play, written in 1957. Looked at now, it has faults. The first act is slow, the whole play is too long, the incidents so lightly linked at times that the audience may feel that it is watching a series of charades involving the same characters. Some of the play is in very speakable prose, some in verse, with an occasional song. All the while the playwright stands aside from his subject, thoughtful and thought-provoking, uncommitted, presenting his characters. This can be difficult for audiences, and so it proved in 1957, when the play received only one showing. Audiences have learned since then, but even now it presents some difficulty. For example, Krank's long dying speech in loose doggerel verse produced alternate bursts of

laughter because of its allusions to so many trite stage deaths; alternating with rather guilty silence that laughter should be the reaction of a man dying. For a play now nearly ten years old, it is remarkably fresh. The problems it dealt with—Rachmanism, for example—had not then received the publicity they have subsequently enjoyed. How many people, laughing at what they took to be references to the Profumo affair, realised that the play was written five years before this burst on the country?

It was not an easy play to produce. So many diverse elements of writing and style, a lot of comedy (always difficult), songs, a large cast. Steve Robins succeeded in giving the play vivid life with many delightful touches of detail. This play needs far more thought and work from the producer than one with a strong line and language an audience will recognise in an instant. The set was by Neil Watson, and consisted of a series of vertical and horizontal frames disposed stage right and stage left with a sort of catwalk at the back. This gave a variety of entrances for the large cast and enough areas for the wide ranging action to take place. Locality was deliberately played down, and successfully indicated by detail alone. The tone of the set was drab, as indicated, but the curtaining at the back was too tatty for comfort, especially since the audience's attention was drawn to it by the many entrances and exits through the drapes.

The acting was mostly of a high standard, especially for a cast of eleven. Most of the opportunities of broad and contrasted characterisation were well taken. Krank, the central figure of the play, was well played by Roger Tudor-Williams. His light and consistent accent, his confident playing right from the very important opening speech, gave the play a firm pivot which it must have. The kern-headed Cassidy, played by Chris Davies, was probably the best all-round performance. He showed fine timing in the many funny passages, and "played" the audience very well. The producer cast white actors as the two West Indians, Bathsheba, a tart, and Joe Caligula, the politician. In this setting of parts nearing caricature this was a success; Bathsheba (Jane Wynburne) was excellent in stance, appearance and gesture but much less sure of her voice; even so, an attempt at a task few professional actresses could manage. David Graham as Caligula, out-Moored the more famous South Bank version in flashing of pink palms and tongue with a bravura performance which delighted the audience. Watching these two players, one wondered what would be the reaction of a white audience to a play in which white parts were played by black actors in pale make-up. We are so used to seeing our own version of the Negro, to the extent that where required the Negro will sometimes play out this version for us. These days are ending, and Genet's "The Blacks" provides some information on the question posed a line or two back. This is not to imply that it is indecent or inappropriate to poke fun at a character not only because he is a charlatan, as Caligula, but because he is a *black* charlatan. This type of fun is one of the highest compliments because it implies—or should imply—a friendliness and equality between the groups involved. But this is not yet the case with the Negro.

Charlie Butterthwaite, the Napoleon of local government, greatly entertained the audience. Here, unlike Bathsheba, voice and delivery were much more successful than stance and movement in suggesting the part. Also, a lot of the subtleties of the part were lost in the successful attainment of broad humour. But the audience loved it. Teresa, the other tart, was played with great aplomb by Angela Krill. She seemed in danger of disintegrating into a flurry of wild gestures at any moment; another fault was that many of her lines were addressed neither to audience or to her fellow characters. Loap, the fatuous M.P., was excellently caricatured by William Hughes; he appeared disturbingly like one of the many gentlemen who solicit our support on the box on behalf of the Conservative and Unionist party. Nowadays the clichè politician would have to be a sort of Super-Loap attempting unsuccessfully to appear as plain Mr. Wilson does. Edward duCann could walk into the part.

Barbara Baulkfast, played by Rosalind Mansell, suffers from being one of a long line of stage Englishwomen. The problem, unsolved in this performance, was to indicate convincingly the affair that had just taken place between her and Krank. Although competently played, Miss Baulkfast remained a stock character. Part of this, of course, lies in the writing, as here also the policeman (Tim Beattie) suffers. His one great moment was beautifully taken when attempting to arrest Paul for shooting Krank. Paul (John Stevens), the other Pole, managed to convey very well the sinister executioner of the play. Alone of all the characters, Paul is rarely used for fun. Finally Henry Ginger, hoarsely brought to very vivid life by Robert Clemmy. His clothes, like those of all the cast, were lovingly worked out and convincingly done. The make-up, also (Tom Treasure) helped to make the appearance of the cast well above the usual standard. Details such as Joe Caligula's hand make-up, are important in a theatre as small as ours.

I have made a number of references to the audience in this review. Let's hope that the Theatre Club won't be deterred from doing modern plays in case audience reaction is poor. After a little uneasiness in that first act, the audience accepted this play on its own terms and settled into an entertaining and thoughtful evening. Any play that can get a roar from the audience is worth doing.

P.S.—"Sergeant Musgrave's Dance" has just opened at the Royal Court; go and see it.

STEWART CAMERON

References to Burns in Children, page 597.

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CORRESPONDENCE

B.M.S.J.

SIR,—Thank you for allowing me to avail myself of part of your correspondence columns to make an appeal to your readers for contributions to the British Medical Students' Journal. This Journal is the official organ of the British Medical Students' Association, the only faculty organization of its kind in the country which has its own Journal. This publication is distributed three times a year: Spring, Summer and Autumn, to all Medical Schools in this country, to be sold to the students and to many Medical Schools abroad—thus it has a very wide sphere of readership.

It has maintained for some years a high standard of content and presentation. But the continuation of this depends on its contributors—YOU. We will consider for publication any article other than a strictly scientific paper; criticisms, witticisms, poems, satire, history of medicine, cartoons and experiences abroad on foreign clerkships.

Yours, etc.,

B.M.S.J.,
B.M.A. House,
Tavistock Square,
London, W.C.1.

COLIN B. BROWN (Editor).

Dean Swift

SIR,—With reference to the recent correspondence in your columns, I should certainly not regard Swift as a neurotic. He refers on one or two occasions to attacks of vertigo in the " Journal to Stella," but there is evidence that this did not become severe till 1738, when he was 71 years old, and he did not become insane till the last few years of his life, when he is said not to have spoken at all for the last two years. It has been suggested, I believe, that he had a slowly progressing eighth nerve tumour, and had a thrombosis of the cavernous sinus at the end.

It is, of course, unreasonable to suggest that he was alienated from some of his friends, notably Dr. Johnson, Thackeray and Macaulay; he almost certainly never was a friend of the first, while Thackeray and Macaulay were born over fifty years after his death in 1745. Macaulay was a stuffy prig, while Thackeray was not entirely against him. Rather curiously, the one thing he attacks Swift most severely for is for leaving a lock of Stella's hair with the pathetic inscription, " Only a woman's Hair," which he maintained was a sign of lack of feeling.

I can hardly believe that anyone can read the " Journal to Stella " without finding a warm place in his heart for Swift.

Yours, etc.,

J. W. SHACKLE.

Guy's Hospital Past and Present Nurses' League

SIR,—May I, through the kind courtesy of your columns, stress to the members of the Guy's Hospital Past and Present Nurses' League that in view of the plans which are now proceeding relating to the production of a League Journal, the customary Christmas Newsletter will not be circulated this year. Members may look forward to receiving the first edition of the Journal during the early spring of 1966.

I would be very grateful if all readers of the *Gazette* could ensure that this information is circulated amongst their own friends and acquaintances as widely as possible.

All of the Nursing Staff here at Guy's send warmest Christmas Greetings and Good Wishes for the New Year to every member of the League both at home and overseas.

Yours, etc.,

ANNE M. JOHNSON,
Matron and Honorary Secretary of the Guy's Hospital Nurses' League.

Guy's Hospital,
London, S.E.1.

The Retirement of Sister A. L. Perkins

SIR,—May I remind *Gazette* readers that the collection which will be handed to Miss Perkins early in January, will close on 31st December next? If this letter should come to the knowledge of new *Gazette* readers, may I explain that during the last two months we have been collecting donations for this gesture and those who would like to contribute may also sign their names in a suitable leather-bound book which awaits their attention in the Matron's Office. The book is divided into three sections:—

Nursing Staff, Past and Present.
Medical Staff, Past and Present.
All other friends.

Those who are abroad and unable to call in to Guy's for this purpose, may certainly forward their signatures on suitable pieces of paper, which will then be affixed into the book accordingly. Receipts will, of course, be dispatched without delay. Cheques should be made payable to "Guy's Hospital."

Yours, etc.,

Guy's Hospital,
London, S.E.1.

ANNE M. JOHNSON,
Matron.

Part-Time Nursing Appointments for Guy's Trainees

SIR,—I would appreciate your support in notifying *Gazette* readers that I am anxious to be able to appoint a Guy's trainee on a part-time basis, for one or two days per week, with the specific task of initiating, assisting and counselling the Nursing Auxiliaries. I would welcome enquiries from anybody who has qualified and/or held an appointment at Guy's during the last ten years.

In addition, I would also welcome enquiries from those of a similar category who might be able to return to us on a part-time basis in wards or departments. Every effort will be made to adjust new professional commitments with the demands of homes and families! I shall look forward to a flood of enthusiastic enquiries!

Yours, etc.,

Guy's Hospital,
London, S.E.1.

ANNE M. JOHNSON,
Matron.

A Lapse of Manners

SIR,—I should like to apologise through your pages to those students who were attending the clinical lecture by Dr. Scott in the Anatomy Theatre on Friday, 26th November. I must, however, point out that the unfortunate collision between this lecture and the meeting of the Anatomical Society of Great Britain and Ireland was a mistake on the part of someone else. Both Dr. Scott and I were placed in an outrageous position, and for my part I am most sorry for the disturbance caused to him and to you. But while it is acceptable that students present at the lecture should have felt aggrieved, this hardly justified the lapse of manners, in the shape of hissing, which ensued. Various societies are quite frequently entertained by Guy's, and it is regrettable that such an exhibition should be made in front of them. Nevertheless, I reiterate my regrets that you, and particularly Dr. Scott, were so inconvenienced.

Yours, etc., ROGER WARWICK.

Department of Anatomy,
Guy's Hospital Medical School.

Mr. R. E. Rix

SIR,—I would be obliged if I could express through your columns my thanks and gratitude to the house surgeons in the Dental Department for Children during the last thirty-six years for their good wishes and magnificent gift to me on my retirement from Guy's. It will always be a reminder of the happy associations and friendship I so much enjoyed. I wish them all the satisfaction and prosperity which was to be expected from their early promise.

Yours, etc.,

R. E. RIX.

40, Harley Street,
London, W.1.

The Dowager Lady Ebbisham

SIR,—It is in affectionate memory that I write on behalf of the members and Executive Committee of the Guy's Hospital Ladies' Association to express their appreciation, love and gratitude to their Chairman of the last thirty-one years, the late Dowager Lady Ebbisham.

She was in her gentle, gracious way, the dynamic spirit of the Association, which went from strength to strength under her wise guidance.

She was always anxious to consider new ideas to provide additional comforts and amenities for the patients and nursing staff, and it was due to her dogged determination that these were realised.

What the patients would do without the Trolley Shop and Library Service, and the nursing staff without the help of the "Flower Ladies," I cannot think, and if the Annual Jumble Sale was to be abolished, I think even Guy's faithful band of daily cleaners might strike!

Naturally the proceeds which these functions realise after expenses are paid, are one of the main sources of the income of the Association; but much more important is the visit of the ladies who run these services which gives so much pleasure to the patients who look forward to their bi-weekly visits, and a little chat!

The Annual Meeting organised by her afforded an opportunity for a social occasion, and for the members to see something of the hospital, and to hear of the wonderful work being undertaken by the medical staff, but not at the expense of good nursing.

The annual outings were always enjoyed by the members, as were the committee meetings held in the beautiful surroundings of her home.

The nursing staff and members of the Guy's Hospital Nurses' League were always delighted to see her at their various meetings and social occasions, in which she took such a great interest.

Her memory was outstanding, as was her interest in people, many of whom have happy memories of visits to Wimbledon, Sandown, the Derby, and as her guest at a Foyle's luncheon.

Those of us who were privileged to enjoy her hospitality will always remember her devotion to her family and how much she looked forward to their visits, particularly those of the older grandchildren who "blew in and out" and who found "Granny's Boarding House" a most delightful and convenient rendezvous.

Finally, how much we all admired her indomitable spirit, and the way she overcame her physical weakness following her accident and subsequent serious illness, for to the end she took an active part in all that was going on and was always her gracious elegant self. How fortunate Guy's was to have benefited from the devoted service of the great lady for so many years of her busy life.

Yours, etc.,

JEAN RECKNELL.

Chantry Green House,
Steyning,
Sussex.

Brighton Stroll

SIR,—The one feature which marred this year's Brighton Walk lunches was the presence of numerous people who had not even crossed Tower Bridge, let alone reached Brighton.

There are perhaps some "realists" who will argue that any excess tickets should be given to all-comers to avoid wastage. It would be as well for all concerned to remember that the lunch and tie are the main rewards for the miserably small proportion of the student body who actually participate in the walk. If these rewards are distributed indiscriminately, as at present, the aim of the walk, for the individual, will speedily be lost. This is obviously a certain deterrent to a healthy level of interest.

Who knows? In some enlightened future year, we may dispense entirely with the physical effort and sit outside the Tower of London, cutting cards to decide the results of the Stroll.

Yours, etc.,

J. K. SKUNE.

248, Albion Road,
Stoke Newington, N.16.

NOTICES

Guy's Hospital
Christmas Holiday, 1965

The following arrangements will be in operation for the Christmas holiday.

ADMINISTRATIVE OFFICES:

The Superintendent's Office will be closed on December 25th, 26th and 27th, but open for urgent business on December 28th.

The Transport Office will be closed on December 25th, 26th, 27th and 28th, and all requests for ambulance transport required after the holiday should be sent to the Transport Office as soon as possible—at the latest by December 23rd. THE AMBULANCE SERVICE DO NOT PROVIDE TRANSPORT TO TAKE PATIENTS HOME ON CHRISTMAS LEAVE OTHER THAN IN EXCEPTIONAL CIRCUMSTANCES.

The Department of Medical Social Work will be closed on December 25th, 26th, 27th and 28th.

The Medical Records Department and the Admitting Office will be closed on December 25th, 26th, 27th and 28th.

CLINICAL DEPARTMENTS:

The following departments will be closed on December 25th, 26th, 27th and 28th, and will re-open on Wednesday, 29th December:

Out-Patient Department.
Physiotherapy Department.
Diagnostic X-ray Department.

The Dental Department will be closed on December 25th, 26th and 27th, and will reopen on December 28th.

The Radiotherapy Department will be closed on December 25th, 26th, 27th, and open on December 28th for treatments only.

Salomons Centre will be closed on December 25th, 26th, and open during the afternoon of December 28th.

No departments will be open on the 25th and 26th December other than the Accident and Emergency Department.

PHARMACY:

The Pharmacy will be closed on December 25th and 26th and open on the 27th and 28th from 9.00 a.m.—12.00 noon. There will be a limited ward basket collection and delivery on December 27th and 28th, but all stock requirements should be anticipated as far as possible during the preceding week.

C.S.S.D.:

The Central Sterile Supply Department will be closed during the afternoon of the 24th December and all day on the 25th and 26th December. The Department will be open during the morning of December 27th and reopens on December 28th.

OPERATING THEATRES:

The main operating theatres will be dealing with emergency operations only from December 24th to 28th inclusive.

P. J. HELLIWELL,
Acting Superintendent.

The Pupils' Physical Society

The second clinical meeting of the term was held in the Demonstration Room of New Guy's House on Thursday, 25th November, at 5.0 p.m. Some thirty students attended.

The meeting was divided into three parts: an X-ray Quiz prepared by the Department of Radiology, a Pathology Quiz with pots gathered by Colin Brown and patients from the wards brought by Robert Morgan. Coffee was served at 6.0 p.m., while the answers were being discussed, and the meeting adjourned just after 7.0 p.m.

A. KUMAR, Hon. Sec.

The Student Medical Education Committee

On Tuesday, December 14th, at 4.30 p.m., in the Anatomy Theatre, there will be an open meeting on " Tutorials for Clinical Students." There will be guest speakers from other medical schools who have tutorials, and all Guy's students and Staff are welcome to come and contribute to the discussion.

Music Club

This year the Music Club's Christmas Concert will be held at Southwark Cathedral on Tuesday, December 14th, at 7.30 p.m. The programme will consist of three works:—

" Missa Brevis" by Kodaly;
" Brandenburg Concerto No. 5 "—*Bach;* and
" Magnificat in D "—*Bach.*

Recently we performed the Kodaly work in St. Paul's Cathedral with considerable success, and the fact that we are doing relatively new work is something of an innovation for the Club. The Bach works include some of the most exciting music written by this great composer.

No tickets are needed and there will be a silver collection in aid of UNICEF.

MICHAEL LINDOP, Hon. Sec.

Psychological Society

On the 30th November, Dr. C. K. Rouse, head of the Department of Psychology at Goldsmith's College, addressed the Society on the subject of "Group Thinking."

In introduction, he referred to Huxley's concept of psycho-social evolution. The speaker's recent research has been to investigate one aspect of this process, namely to study the effects of group membership on psychological processes of conceptualisation of the individual members of the group.

Le Bon introduced the idea of mental unity of a crowd and claimed that the crowd is intellectually inferior to its constituent members. Dr. Rouse's work has been to evaluate the relative efficiency of groups and individuals in solving a variety of problems. Groups of one to five individuals were used, and within each group members were of the same sex and approximately the same age and test intelligence.

The initial experiments used problems based on the schoolboys' game of "battleships." This test enabled the observing psychologist to record the ways in which groups gathered information, formed hypotheses, tested their hypotheses and formed concepts. Detailed analysis of the results and of tape recordings of group conversation during the test revealed systematic methods of attack and the following facts:—

(1) Intellectual leadership swings from person to person in the group.
(2) There was increased scanning (i.e. the use of varying techniques) in the less efficient groups.
(3) Efficient groups spent 60% of their time on one strategy.

For simple problems of this kind, the individual apparently fares better than the group. However, it was found that the efficiency of a group exceeded that of the individual when more complex problems were introduced. Thus a group of four could achieve results beyond the capabilities of the individual. This superiority was achieved at the cost of suppressing the number of aspects appreciated by individual group members. *Thus, each member perceives less, but the group achieves more.*

The speaker then outlined some of the methods of research he intends to use in the future, notably an approach analagous with genetics in which ideas fed into individual group members are the resultant group concepts and are studied to decide which ideas were dominant and which recessive.

Dr. Rouse's experiments have thus been aimed at investigating the efficiency of the group compared with that of the individual, and also to decide what sort of problems are best solved by groups. His results, which have obvious practical application, both in industry and education, also open up a vast field for further psychological research.

G. V. PAY (Secretary).

REVIEWS

A NEW LOOK AT GERIATRICS.

R. Kemp. Pitman Medical Publishing Co.

This little monograph is one of the series, " A new look at Medicine." As it says in the introduction, this look describes the study and prevention of morbid trends in ageing. It is really a plea to doctors to seek out and destroy the seeds of senile morbidity sowed in middle age. Thus he says: " In my opinion we cannot hope for much progress in geriatrics unless the geriatician extends his interest to the years before he is called in as a clinical undertaker." The corollary might be for the general physician to eye the developments of middle age with suspicious concern for the patient's twilight years.

Dr. Kemp has written a scholarly and challenging account of most aspects relating to geriatrics, and I feel that it is a book that should be read by all doctors, students and others concerned with the well-being of old people.

MARTIN JOURDAN.

BIO-CHEMISTRY FOR MEDICAL STUDENTS.

Thorpe, W. V.

When a book has been published for more than twenty-five years, as this one has, one would think that to review it was unnecessary, for opinions will already be well formed about it.

It cannot, of course, compare with the large American text books of biochemistry, but should it be compared, at less than half their price? In about six hundred pages it introduces the student to nearly his whole course in biochemistry. There is not a wealth of detail, but enough to provide a reasonable background in the subject and supplement the lecture course. When one consults a large text book it is often difficult to know where to draw a line and judge what is required for 2nd M.B.

Seeking after minutiae can best be done in the reference library, while this book is cheap enough to have on one's own shelves at thirty-six shillings, and contains sufficient information for most students.

The new edition has been revised extensively, and a new chapter on energy included, although only four pages long. Where new ideas have arisen, e.g., on fatty acid synthesis, the text has been brought up to date. The chapters on carbohydrates, proteins, nucleic acids, and others have been revised, and on the whole, for what it is, the book gives good value for money.

ROGER SALT.

MODERN NURSING, THEORY AND PRACTICE

by Winifred Hector. Published by Heineman. 3rd edition. *Price* 30*s*.

Already established as a sound and comprehensive text book of nursing since the first edition was published in 1960, this 3rd edition has been revised in order to keep up with the ever changing pattern of medicine and nursing care.

This book now contains sections devoted to positive pressure respirators, external cardiac massage, cytotoxic drugs, radio active isotopes, liver function tests, central sterilization and disposable stock. Like the rest of the text, these are written in a clear and concise manner and provide the relevant information which it is necessary for a nurse to know.

As the author states in her preface, some of the procedures which may appear obsolete have been retained for the benefit of a "world wide market" since many nurses still use them. Those unfamiliar with the previous editions will find that this book fully covers all aspects included in the General Nursing Council syllabus. The text is skilfully and simply written, each section has a helpful brief introductory paragraph. The numerous illustrations are both clear and relevant.

H.H.W.

SPORT

The past fortnight has seen much activity from the Hospital's sports clubs, the Boxing and Boat Clubs claiming their share of the limelight from their Rugby, Hockey and Football associates.

In a four-cornered encounter with the Lynn, Belsize and London University Clubs, the Boxing Club produced another entertaining exhibition of the noble art on Tuesday, 23rd Nov. In two commendable bouts, Gibson and Onyeama demonstrated the finer points in gaining hard-fought, skilful victories, while Guy's other contenders concentrated chiefly on emphasising the importance of fitness to the spectators, who quickly got the message. "Oh, I had a game of squash last night," one contestant cheerfully announced before his bout. He looked less cheerful immediately afterwards.

The winter training programme of the Boat Club culminated in two very successful and by all accounts equally enjoyable events—the United Hospitals' Winter Regatta and the University Winter Eights. The junior crew won the novices section of the latter, rowing three splendid races in all, while success was shared by all in the former. The greatest triumph was that of the "Rugger Four" (genuine oarsmen, it seems, not footballers), whose greatness was measured by the size of their cup, which held some eleven pints and was drained ceremoniously many times in the course of the evening that followed.

The Hockey Club has advanced into the next round in its quest for the Hospitals Cup following a comfortable win against King's. A defeat 4—1 against Merton and a draw against the unbeaten Bexleyheath complete a fortnight of mixed fortunes.

The abundance of talent enjoyed this year by the Rugby Club, while greatly improving the strength of the sides, has greatly increased the problem of selection. Many fine players have appeared for the 1st XV this season, and as the first cup match looms near, the captain, John Davies, finds himself in an unenviable position where continuing experimentation is demanded. The team consequently has yet to settle down properly and its performance of late has been somewhat disappointing. The difficulties will surely be overcome in the near future, however, and we look forward to the success of which the side is well capable.

The increased power of the Club is at present better illustrated, perhaps, by the junior sides, now numbering seven, who consistently win and often by large margins. The "A" XV have now won their sixth successive victory, scoring some 120 points without seeing their line crossed.

Two weeks ago the 1st XV met Stratford-upon-Avon and lost a hard fought duel 14—10. This was the Hospital's first fixture with Stratford and proved most enjoyable. Last week the side was defeated away by Streatham/Croydon 11—6 in another hard-fought, wet encounter, where the stronger looking home side was able to take more advantage of the few chances that occurred.

SPORTS DIARY

Wed., Dec. 8th.
Football v. Middlesex Hospital. Home (League).

Sat., Dec. 11th.
Rugby v. Old Cranleighans. Away.
Football v. Westminster Bank. Away.
Hockey v. South Essex. Home.

Tues., Dec. 14th.
Boxing v. Metropolitan Police, "F" Division, at Ravenscourt Park.

Sat., Dec. 18th.
Rugby v. Esher. Home.

REPORTS & RESULTS

RUGBY

GUY'S v. STREATHAM/CROYDON

Away. Saturday, 4th December, 1965
Result: lost 11—6

Having lost their two previous games very narrowly to the Metropolitan Police and a very good Stratford-upon-Avon side respectively, Guy's ventured down to Thornton Heath with the prospect of another very close game against Streatham/Croydon. Having been dry in the morning, the slight drizzle that began just before the kick-off, and persisted throughout the game, seemed to dampen the enthusiasm of both sides to play adventurous attacking rugby, apart from a few electrical bursts from both fly-halves at various intervals during the game.

Streatham/Croydon kicked off, but were soon on the defensive as the Guy's pack took advantage of the home forwards lassitude in the opening encounters. The first two scrummages were won against the head by Hey, and although Cheeseborough made some fine breaks, the onslaught was curbed and for the rest of the half the home side had the majority of the play. After 20 minutes, following a mêlée near the Guy's posts, one of the home forwards picked up a roving ball to score. The kick failed. This spurred Guy's to greater efforts, but just as the pack were again attempting to gain the upper hand, one of the Streatham forwards gathered a drop-out from his own fly-half, and before the Guy's defence could come back, had run seventy yards, kicking over Elliot's head, for one of the wing forwards to score. The kick was converted, and the half-time score was 8—0.

The second half began with Streatham, through their captain, B. Richards, at fly-half, astutely keeping play mostly in Guy's half. However, after 15 minutes, Cheeseborough scored a brilliant try for Guy's. Breaking on the blind-side of the scrum, his acceleration was such that he scored wide out without a finger being laid on him. Elliot failed with the conversion.

Unfortunately the Guy's pack could never quite master the Streatham eight and as a result the threequarter line very rarely had the opportunity to attack. Streatham put the nail in the coffin with a penalty in front of the posts, and Elliot did likewise from 35 yards to make the final score 11—6. This was a disappointing show by the Guy's forwards who have up until now played extremely well.

J. E. DAVIES

HOCKEY

GUY'S v. KING'S COLLEGE
Inter-Hospital Senior Cup (1st Round)

At H.O.P. Wednesday, 24th November, 1965
Result: won 5—0

With a still unsettled regular team, Guy's met King's in good conditions on a pitch that promised some good hockey. The small, but noisy, band of supporters were not to be disappointed. Inevitably, Guy's were slow to start, and for the first quarter of an hour they tried to mimic the mediocre play of the opposition. However, their confidence was soon restored when Bennett converted a short corner.

Guy's continued to play smooth, open hockey with the forwards always making gaps in the King's defence, and it was not long before Appleby scored on a solo run. He followed this just before half-time by scoring from a hard-hit pass from the right-half, Crafts.

In the second half Guy's did not cease to exert heavy pressure on a thoroughly outplayed King's team. Of particular note were some good movements on the right which culminated in Cripps scoring by a very hard shot from the edge of the circle. Although King's were obviously very dispirited, they were always harrassing our attack to good advantage, but a fifth goal by Bennett just before time gave Guy's a decisive victory.

This result was undoubtedly produced by an all-round team effort. Everyone in the team, which included Lallemand (a member of the 1960-61 cup winning side), played a consistently hard game, and the Club has every hope that the Cup will soon return to its rightful place.

E. N. TURFITT

Team: S. Rear; D. Loader, R. Kendrick; J. Crafts, C. Brooks (Capt.), R. Lallemand; R. Carruthers, S. Cripps, M. Appleby, P. Bennett, C. Pearson.

GUY'S v. MERTON

Away. 28th November, 1965
Result: lost 4—1

The game against Merton was played in appalling conditions. The pitch was extremely soft from the heavy rain of the morning, and conditions were made worse by the gale-force winds. The game was lost because of the team's failure to get above the conditions and the complete lack of covering for a period in the second half when three of the four goals were scored.

At the beginning of the match Guy's looked as if they might do well with the ball being moved to the wings. Within the first ten minutes this resulted in a golden opportunity when Pearson crossed the ball hard from the left. One of the Merton defenders managed only to partially stop the ball and it ran clear into the centre of the circle. With the Merton goalkeeper out of position the Guy's forwards failed to capitalise on this error and the ball was eventually cleared by the Merton left-back. This was the only flash of excitement in the first half; the remainder being spent mainly bogged down in the midfield.

After the change-round Merton seemed a different team. Their inside trio banged the ball around and their right wing, who was given far too much room, was able to make a number of very dangerous runs. With Guy's defending most of the time a goalmouth scramble developed and Rear was forced to drop on a ball to prevent Merton from scoring. This resulted in a penalty flick, which was converted with due ceremony. Merton now took command of the game and pressed hard. The inside-left beat the defence and carried the ball to the bye-line, drew Rear out of goal, and then passed the ball back to the centre-forward, who being the only other player in the circle, scored easily from four yards. From the restart Merton were back in the attack. A sixteen yard hit went straight to the Merton centre-half, who passed the ball through the Guy's defence to the inside-right who cracked the ball into the net. Guy's now started to play a little better hockey and forced a short corner. From this, Loader cracked the ball from a narrow angle past the Merton goalkeeper. Merton's fourth goal was scored by their right-half who, after collecting the ball on the halfway line, eventually scored after a fine combination of hockey and soccer.

This was the most disappointing display by the team this year. The whole side looked listless and played well below the standard of which they are capable. It was a complete anticlimax after the Cup game.

Team: S. Rear; D. Loader, M. Horrocks; J. Crafts, C. Brooks (Capt.), P. Rushmer; R. Carruthers, S. Cripps, M. Appleby, P. Bennet, C. Pearson.

R. KENDRICK

BOXING

GUY'S, LONDON UNIVERSITY, LYNN, BELSIZE

Pavy Gym. 23rd November, 1965

Guy's were the hosts in this, the fourth annual match of its kind, between teams from London University, Belsize, The Lynn, and Guy's Hospital boxing club. Of the nine bouts, Guy's were represented in eight, and produced winners in three of these. The discrepancy between bouts fought and bouts won can be almost totally explained by lack of fitness on the part of the Guy's boxers, rather than by inferior skill.

In the opening bout of the evening, K. Hughes looked likely to give Guy's an early win against his opponent from the Lynn, and for one-and-a-half rounds was the constant aggressor, landing several hard right crosses. Gradually, however, as Hughes visibly tired, his stronger opponent countered effectively, and in spite of a last minute rally by Hughes, the Lynn boxer was awarded a close verdict.

The tall J. Crawford, in another bout against a Lynn boxer, used long left leads to keep his stocky opponent at bay, and aided by a perfect back handed left swing in the final round won a close decision.

In the next bout D. Edgar, veteran of some 22 bouts, met an Australian, boxing for the Belsize club, reputed to have had 50 previous bouts. Nevertheless, neither boxer met with much success as regards hitting his opponent and it was only the greater fitness of Ryan, the Belsize boxer, which allowed him to get on top. Eventually the exhausted Edgar was led back to his corner after taking a count of three in the final round.

The referee's decision was loudly contested in the next bout when D. King, of Guy's, boxing in his first contest for Guy's, was not permitted to complete the first round against a stronger Belsize opponent. King had shown considerable ability up till this point, with fast left jabs, and at no time looked to be in any great difficulty.

The best bout of the evening followed, between T. Gibson, of Guy's, and his tall opponent from London University. This bout, between two fit and skilful boxers, followed the same pattern in all three rounds, with Gibson beautifully countering his opponent's long left leads with his own left hand. The decision, which must have been very close, was awarded to Gibson after a fine contest.

A. Leyshan, of Guy's, although showing great determination throughout, was clearly no match for his stronger opponent from the Lynn, and did well to last out the three rounds in spite of taking a compulsory count of eight in the final round.

The bout between B. Hartley, of Guy's, and V. Rutherford, from the Lynn, was a wild affair between two strong but rather less than classic boxers. Rutherford's greater stamina showed in the final round, but both boxers were still standing toe to toe swinging away at each other as the final bell went. Rutherford was awarded a close decision.

The evening reached its climax in the final bout, between W. Onyeama, the Guy's Captain, and B. Stubbings, Captain of the Belsize club. Onyeama started well against his stocky opponent, keeping the fight at a distance with left jabs to the face, but by the end of the second round Stubbings had succeeded in disturbing his opponent's composure by launching two-fisted body attacks, admittedly few of the blows landing cleanly. Nevertheless, Onyeama's greater skill allowed him to pile up valuable points with his left hand, and he was awarded a close, but deserved decision.

A. L. STANHOPE

BOAT CLUB

UNITED HOSPITALS' WINTER REGATTA

The regatta was an outstanding success this year, despite shortages of equipment. Having entered six out of nine events, club crews, during an exciting day's racing, reached five finals, winning three.

The Junior VIII entered for this year's regatta was in fact our Second VIII (the 1st VIII was too good to be eligible), and having drawn a bye in the first round, had the satisfaction of watching their competitors fighting it out. Racing against Bart's 2nd VIII, Guy's showed their latent strength and know-how by convincingly rowing down the opposition, to win by 2—3 lengths. In the final Guy's met the Bart's 1st VIII—a well trained and experienced crew—and although going down from the start, the crew remained unflappable. Unfortunately Guy's were outclassed, losing by 2—3 lengths, but were well pleased with their best row of the day.

The Junior IV was a crew made up of members of the first VIII. They had not rowed in a clinker-four boat for some time, nor had they rowed with this combination of crew. Therefore they were somewhat apprehensive, to say the least. Practice racing starts gave no re-assurance and proved to be a weak point during the heats. In the first race Mary's were given a length off the start but after the first minute Guy's settled into a steady paddle (hardly a "row") forcing Mary's to "blow up" near Quintin Boathouse. The crew managed a reasonable start in the second heat, against Bart's, setting a fast pace and going up straight away, to win by 2 lengths. After two minutes Bart's never looked dangerous. In the final Guy's met St. Thomas's—a lively but worried crew. Again at the start a quarter-length was dropped, but quickly regained. "Tens" by St. Thomas's were easily held, and at about Chiswick Bridge they were lost to sight! This crew rowed very well behind R. Forrest's excellent stroking and C. Woodhouse's equally excellent coxing.

This year Guy's Rugger IV took the honours. The backbone of the crew was two members of last year's 1st VIII, well supported by two more distinguished oarsmen in the bows. This crew, having beaten the Royal Dental Hospital easily, to everybody's, not least their own, surprise, decided to win the other heats as well. The cox's inspired steering was due in part to a desire to lure the opposition into the bank, and in part to the ale consumed since the first round. The final against Mary's showed just what sheer guts and determination can do. The hard-fought race brought a well deserved cup (holding 11-12 pints).

The novice oarsmen show special promise this year. They were very keen despite the usual training difficulties to which they have been subject. Of the two novice crews, the "B" crew rowed first. They were defeated after a good performance (overcoming a broken seat) by U.C.H. The latter was later disqualified for entering non-novice oarsmen, giving us a technical victory, too late, however, for the "B" crew, who had gone home. The novice "A" crew easily defeated a Mary's crew and in the semi-final met St. Thomas's, whom they lost to by three feet. A fine effort since the latter went on to win by nine lengths in the final.

S. Gregson entered this year for the Senior Sculls, having won the Junior Sculls last year. A scratched entry put him straight into the final, which he narrowly lost to O'Carroll, of Bart's. This was a plucky effort as he only had a short training programme. In the Junior Sculls we were represented by Paul Gooder, and our faith in him was completely justified.

In his exciting races we scarcely saw his opponents from the river bank. Even in the final, against Humphrey, of U.C.H., the verdict was "Easily".

Junior Four		Rugger Four	
Bow	J. Pook.	Bow	J. Williams.
2	R. Mandeville.	2	J. Skuse.
3	P. Burton.	3	D. Jesset.
Stroke	R. Forrest.	Stroke	K. Sommi.
Cox	C. Woodhouse.	Cox	R. Illing.

ATHLETICS

U.L.A.C. Winter Field and Track Events Meeting

Motspur Park. 17th November, 1965

Results: Field-events competition: won; Relay Cup: lost to King's.

The eleventh winter Field Events and Relays Competition of the University of London Athletic Club was held at Motspur Park on Wednesday, 17th of November, at 1.30 p.m. Guy's, winners of last year's Relay Cup, were represented by a team rather limited in numbers by injuries to several members. The most notable contribution was that of G. Edwards who performed well on a cold and rainy day. Good performances by D. Osborne in the discus and by G. Ross, a new member of the team, in the shot gained valuable points. The combined effort of our athletes in the field events won us the "Tjalve" Fields Events Trophy.

Luck was not on our side in the Relays competition on account of an unfortunate incident in the 4 x 110 relay. D. Briggs, M. Cheesborough and I. Morgan did well to come second in the 220 x 220 x 440 relay, and finally we gained a place in the 880 x 880 x 1 mile relay. King's College won the "University College Relay Cup" following wins in all three relays.

Competitors and Results:—

Discus: D. Osborne, 128ft. 8ins. (1st) and G. Edwards

Shot: G. Ross, 44ft. 6ins. (1st) and G. Edwards.

Javelin: G. Edwards, 173ft. (2nd) and B. Hartley, 166ft. 9ins. (3rd).

Pole Vault: G. Edwards, 8ft. 6in. (3rd).

Triple Jump: A. Warin and G. Edwards.

Long Jump: M. Cheesborough and A. Warin.

High Jump: A. Warin and B. Hartley.

4 x 110 Relay: P. Bundred, M. Cheesborough, I. Morgan, F. Nwator (Baton dropped).

220 x 220 x 440 Relay: M. Cheesborough, D. Brigg, I. Morgan (2nd).

880 x 880 x 1 mile: D. Briggs, D. Choat, P. Witting (6th).

P. M. J. DOMAINGUE,
Hon. Sec., G.H.A.C.

CROSS-COUNTRY

On Wednesday, 10th November, we had a match against St. Mary's College, Twickenham, 2nd team. It was a fine afternoon and the going good underfoot. We were a little discouraged to find first teams from King's and University Colleges also competing. J. Wheeler, starting at the back of the field, worked his way towards the front giving great encouragement to the Guy's men as he passed them. Guy's finished 3rd, ahead of St. Mary's II. On Saturday, 13th November, D. Vernon, B. Avery and E. Bowen-Jones ran for United Hospitals against Barclay's Bank and the Bank of England. All ran well, but who wouldn't on so cold a day? U.H. won comfortably.

On Wednesday, 17th November, Guy's took on Imperial College's first team in Richmond Park, though both teams were depleted. In a very close match, with much juggling with positions, I.C. won by three points. Enfield and Kingston technical colleges also competed. This was an encouraging result and should give more morale in future fixtures.

The position in the league is 8th out of 14 in the first division.

Results:

Guy's v. St. Mary's		v. King's	
9	Smith.	21	Vernon.
14	Wheeler.	32	Henry.
15	Waterhouse.	1st, U.C., 23 points.	
16	Avery.	2nd, King's, 31 points.	
18	Watson.	3rd, Guy's, 72 points.	
19	Bowen-Jones.	4th, St. Mary's, 132 po	

Guy's v. Imperial College.			
2	J. Wheeler.	14	E. Bowen-Jones.
4	B. Smith.	15	G. Waterhouse
7	B. Avery.	27	M. Henry.
11	R. Wilson.		

30 ran.

Imperial Col., 35; Guy's, 38; Kingston Tech., 74

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL DENTAL SCHOOL

Applications are invited for the post of **Full-time Lecturer in the Department of Dental Prosthetics.** Salary in the scale of £1,580 x £110 to £1,690 x £115 to £2,150 x £110 to £2,480 x £55 to £2,535, with superannuation. Appointment to date from 1st April, 1966. Forms of application are obtainable from, and should be lodged with, the Dean, Guy's Hospital Dental School, London, S.E.1, not later than **Thursday, 16th December, 1965.**

PRIZE LIST

PRIZE IN CHILDREN'S DENTISTRY, INCLUDING ORTHODONTICS

October, 1965

The following Awards have been made:—

First Prize—Miss S. Parry

Second Prize—P. A. Sims

PASS LIST

UNIVERSITY OF LONDON

M.D.S.

A. H. R. Rowe

Ph.D.

Gillian B. Fowler

FACULTY OF RADIOLOGISTS

Fellowship

B. J. Cremin

UNIVERSITY OF LONDON

Third M.B., B.S., October, 1965

Pass list

M. B. Barnett	A. W. J. Medhurst
P. J. R. Cox	G. J. D. Moore
D. H. Evans	H. Munitz
J. W. B. Franklin	D. J. O'Gorman
D. G. Gourley	Jennifer P. Pearse
J. S. Gregson	T. N. D. Peet
A. J. Hazzard	B. S. Pound
M. J. Hoyle	J. C. Robertson
T. N. Jones	G. G. Stimpson
C. E. M. Lamb	R. A. Sturge
W. T. Lamb	I. A. Sutherland

Christina J. S. Lawrie

Part 1

M. K. Anto	M. E. Pembrey
T. S. Brown	C. A. C. Pickering
Mary T. Cunningham	P. C. Pietroni
S. F. Din	Theresa D. Pietroni
K. N. Dunn	A. E. Raynes
D. P. Evans	H. E. G. Rees
H. Gareboo	D. J. Rhodes
T. J. Gibson	J. M. Richards
T. H. Guerrier	Lyall M. Rikard-Bell
Helen Hale	I. F. Roberts
D. J. Hendrick	G. F. Rushforth
D. L. Ingram	J. F. Searle
M. H. Jourdan	D. C. Siggers
M. R. L. Joyce	G. Smith
Susan L. Kramer	W. Snidvongs
Joy S. Lawrence	R. A. J. Spurrell
D. P. Leiberman	A. L. Stanhope
S. O'D. McCall	Clare E. Stannard
T. MacLennan	Isobel M. J. Stephen
C. P. Malpass	D. Tong
D. K. Masters	Jennifer R. Townsend
D. B. Mathias	T. D. P. Underwood
Carolyn J. Mowbray	J. J. Wallace
C. L. Newman	C. J. Watson
J. A. Nicholson	T. L. S. Williams
G. G. Parfitt	

Part 2

P. J. C. Baxter	G. Llewellin
R. F. C. Boger	Sophie Robertson
R. J. R. Boyd	M. S. Vernon
W. A. K. Burke	J. J. Wallace
P. S. Hughes	

Part 3

P. J. R. Boyd	Sophie Robertson
W. A. K. Burke	Jennifer R. Townsend
C. D. G. Johnson	M. S. Vernon
B. J. Mason	P. A. D. Williams

Part 4

W. V. Annan	D. L. Ingram
P. J. C. Baxter	R. H. Thacker
A. K. S. Cheng	Jennifer R. Townsend
N. J. Healey	J. J. Wallace
P. S. Hughes	P. A. D. Williams

ROYAL COLLEGE OF SURGEONS OF ENGLAND

L.D.S. First Examination

Anatomy and Physiology

K. R. Band	C. J. T. Howell
C. S. Blockley	P. W. Lambden
C. J. Cox	D. G. Lewis
S. N. Cripps	J. M. B. Ludford
C. R. Debenham	G. Morris
J. C. Edwards	W. M. Roston
W. G. Gill	Jennifer H. Scholes
N. R. Hopkinson	G. L. Standring

Special Anatomy and Physiology

K. R. Band	N. R. Hopkinson
C. S. Blockley	C. J. T. Howell
G. F. Brown	P. W. Lambden
I. M. Copeland	D. G. Lewis
C. J. Cox	J. M. B. Ludford
S. N. Cripps	Jennifer M. Scholes
J. C. Edwards	G. L. Standring
W. G. Gill	M. G. Taplin

NURSING NEWS

Final State Examination, October, 1965

The following nurses have passed the Final State Examination held in October, 1965:

Austin, D. A.	Hoather, A. M.
Beattie, A. M.	Holmes, W. N.
Beattie, R. F.	Homer, P. M.
Beckett, M.	Hutton, M. P.
Beveridge, A. G.	Jones, E. A.
Birnage, J. A.	Jones, V. S.
Bourne, J. E.	Knight, M. J.
Bradley-Watson, E. M.	Lampitt, E. O. M.
Buckle, J. M.	Lees, F. A.
Burnett, D. M.	M'Caw, P. S.
Burridge, P. J. M.	McCord, S. E.
Butcher, M. C.	Marsh, S. A.
Cantin, B. M. (née Crossland)	Mister, J. M.
Chalder, J.	Partridge, E. A.
Clay, S.	Payne, L.
Collins, G. S	Pearson, B. A. (née Jones)
Deasley, V. J.	Pickstock, E. A.
Dick, C.	Pozzi, J.
Dove, J. M.	Reckitt, J. M.
Dowling, M. J.	Rowe, J. F.
Dunlop, G. A.	Runcieman, C. L.
Farnworth, J. A. (née Lomas)	Skinner, F.
Featherstone, A. E.	Smith, L. M. (née Sirot)
Fincham, C. F.	Tierney, N. M.
Fort, V. W.	Tydeman, P. M.
Giles, S. M.	Waddingham, S.
Griffiths, S. E.	Westley, M. V.
Hastings, P.	White, D. J.
Hind, A. J. D.	Wilkes, E. A.

Combined Training with Nuffield Orthopaedic Centre, Oxford.

Bellis, B.	Side, S. H.
Jones, M. E.	Stenhouse, M. E.

Birth, Marriage, Death, and Change of Address notices are without charge to subscribers. For Personal notice the charge is £1 1s. 0d. for 15 words, additional five words 10s. 6d., minimum 15 words. Non-subscribers will pay £1 1s. 0d. for all notices other than Personal which will be charged at the above rate.

PERSONAL

If there is a Dental Surgeon wanting a position as assistant, an all-Guy's practice in the West End (principal and two assistants) looking for a successor for one of the leaving assistants, would welcome a call. WELbeck 9433 or Box No. 50. Five-day week, 9.30—6 p.m.

CHANGES OF ADDRESS

ZILKHA.—Dr. and Mrs. K. J. Zilkha, to Little Mead, 11, Alleyn Park, Dulwich, S.E.21. Telephone No. Gipsy Hill 2886.

MORRIS.—Dr. George Morris, to 169, Cranley Gardens, London, N.10. Telephone No. Tudor 3421.

BIRTHS

ZILKHA.—On October 29th, at King's College Hospital, to Judith (née Mogridge) and Kevin Zilkha, a son, Jonathan Mark, a brother for Timothy and Caroline.

DEATHS

WOOD.—On November 23rd, 1965, suddenly at his home, Russells Cottage, Hurstpierpoint, Sussex, W. R. J. (Rex) Wood, L.D.S., R.C.S.(Eng.), dear husband of Betty and dearly loved father of Jenny and Christopher and father-in-law of Migo and Tony.

BAILEY.—On November 29th, 1965, aged 54 years, Leslie James Bailey, L.D.S., R.C.S.(Eng.), of Lyndhurst Habertonford, dearly loved husband and father.

EDITORS A. E. RAYNES and M. F. D'SOUZA
SPORTS CORRESPONDENT D. J. HENDRICK
FORTNIGHTLY TWO SHILLINGS VOLUME 79 NUMBER 2019

GUY'S HOSPITAL GAZETTE

CHRISTMAS EDITION December 23 1965

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ON THE OCCASION OF

CHRISTMAS

* * * MAY WE WITH * * *

UTMOST CORDIALITY

EXTEND TO YOU

FELICITATIONS

AND MAY UNBOUNDED

SUCCESS

ATTEND YOUR DIVERSE ENDEAVOURS, BOTH

DOMESTIC AND PROFESSIONAL

THROUGHOUT

THIS AND EVERY YEAR

Somebody's Christmas

The time of goodwill is here, of Happy Christmas, tinsel and bells. As usual, the hospital celebrates in the Guy's tradition, the wards are decorated, carols are sung round the hospital, there are dinners, shows, laughter and happiness. The staff enjoys its annual diversion into merriment with all people at all levels. There is an easy atmosphere, pressures are temporarily pushed aside, the work becomes lighter and is accomplished with smiles, but the patients will think about home.

In the few weeks before Christmas, the country rushes headlong into its preparations, bursting Oxford Street at its seams. Advertising sells Christmas everythings and people accept the intensified programme against drinking and driving; it's all part of the celebration and besides, it could never happen to them. The road toll has become part of the Christmas trappings. People in hospitals, especially the aged, enjoy an increased publicity at this time of year, but for the rest of the year, like the road toll, they are accepted and forgotten.

It is Christmas for the distressed as well. Old people in pathetic single rooms, living with thoughts, and a photograph or two, feeding on the goodwill of others, all will know some sort of Christmas this year. The distress of some, however, will pass unnoticed, as will that of the estimated 700,000 children (seven per cent of the nation's young) who are living beneath the accepted standards which are compatible with the necessities of life. To some extent their plight has been engineered by the built-in incentive policies of the National Assistance Board, the official charity of the Welfare State. Perhaps the answer to this inconsistency, like many others, could be found if it was approached with the atmosphere of true human charity that is always associated with Christmas.

The University of London has conferred the title of Professor of Anatomy on Dr. J. Joseph as from December 1st. We offer him our sincere congratulations.

The Editors would like to thank four people for their help in producing this Christmas edition of the *Gazette:* Marcus Pembrey for his article "Feeding for Thought", Stephen Robins for his review, Neil Watson for his drawings, and Bob Morgan for his game. We must explain that although parts of this *Gazette* bear little relation to the present, however much we would like them to, we present them for your amusement and possible nostalgia.

It looks like love

Christmas is undoubtedly a romantic time of the year, for even though the passions of Spring are still hibernating, the low temperature of the climate seems to be ample drive in bringing people together—and where there is juxtaposition there is love. In hospital, too, despite the central heating, this seasonal effect is no less marked and many otherwise brief encounters are transformed into full-blown affairs: for here cupid carries an unerring hypodermic that homes into the upper outer quadrant before questions can be asked. But although the nurse has been a heroine of fantasy ever since the days of Crimea, it is only in recent years that the doctor has risen to reach his present remarkable stature as a romantic figure.

Now, every women's magazine in the country, and many abroad, regularly feature as the hero of their centre page love story a handsome young doctor, and whether he is a Philishaved laconic surgeon or a Gilletted debonair physician, the net effect in terms of amatory tachycardia is much the same. Television, too, has its seat firmly on the band-wagon with Drs. Kildare, Ben Casey, Findlay and others all doing sterling service for the cause of true love: (the most recent addition to this branch of the profession, a certain Dr. Richard Kimble, apparently claims to have done some of his post-graduate training here at Guy's!)

The question is, however, why doctors? Why not dentists? Why not pig-farmers or stock-brokers?—They are all much richer and keep better hours. In many ways the choice of the medical man to fill the rôle of romantic hero is hard to understand, but the myth is continuing to grow and it is rare to hear anyone in the profession objecting. Indeed, one is tempted to speculate on how many of our present-day students, loitering hopefully under the mistletoe, received their initial vocations from watching the glamorous successes of those gallant actors of the little screen.

GUY'S DIARY

DECEMBER

Exhibition:			The Acute Abdomen
31st	Fr.		Clinical Lecture. Mr. R. H. F. BRAIN.

JANUARY, 1966

3rd	M.	1.00	Clinical Lecture. Mr. MURRAY FALCONER.
4th	Tu.	1.00	Clinical Lecture. Mr. BEARD.
13th	Th.	1.00	Clinical Lecture. Dr. HARDWICK.
17th	M.	1.00	Clinical Lecture. Dr. HALL.
18th	Tu.	1.00	Clinical Lecture. Dr. MANN.
20th	Th.	1.00	Clinical Lecture. Mr. WILLMORE.

Time Table of Events at Guy's Christmas, 1965

THURSDAY, DECEMBER 23RD.

4 p.m.	Dressers' Teas and Ward Decorations.

FRIDAY, DECEMBER 24TH,
Christmas Eve.

4 p.m.	Dressers' Teas and Ward Decorations.
11.30 p.m.	Midnight Eucharist in the Hospital Chapel.

SATURDAY, DECEMBER 25TH,
Christmas Day.

6—7 a.m.	Nurses' Carols in the Wards.
8.20 a.m.	Holy Communion, Hospital Chapel.
7.30—8 a.m.	Nurses' Breakfast in the Nurses' Home.
10.30—11 a.m.	Morning Service, Hospital Chapel.
12 mid-day.	Patients' Christmas Dinner.
1—2 p.m.	Resident Domestic Staff Dinner in Tabard House.
1 p.m.	Nursing Staff Christmas Dinner in Wards.
3.30—4.30 p.m.	Patients' and Staff Tea in Wards.
7.30—8.30 p.m.	Nurses' Supper in the Wards at the Sisters' discretion. All Day Nurses to be off duty and out of the Wards by 8.45 p.m.
9 p.m.	The " Christmas Show " by the Students in the Physiology Theatre.

SUNDAY, DECEMBER 26TH,

6 a.m.	Patients' Communion in the Wards.
7 and 8.20 a.m.	Holy Communion, Hospital Chapel.
10.45 a.m.	Morning Service, Hospital Chapel.
2—4 p.m.	Visitors' Teas in the Wards.

MONDAY, DECEMBER 27TH,
Boxing Day.

6 p.m.	"Christmas Show"' by the students in the Physiology Theatre.

1966.

THURSDAY, JANUARY 6TH,

7 p.m. for 7.30 p.m.	Sisters' Dinner in the Nurses' Dining Room.

THURSDAY, JANUARY 13TH,

7 p.m. for 7.30 p.m.	Staff Nurses' and Staff Midwives' Dinner in the Nurses' Dining Room.

FEEDING FOR THOUGHT — Breast is Best

At this season of the year, it has become customary to over-indulge grossly in things material, and the abuse of good, wholesome food, especially when it is thrust upon our innocent little ones, is a practice that is to be deprecated. One sees only too frequently the modern infant being fed when it so desires; and indeed, some misguided physicians even advocate this course of action! This permissive attitude, especially in the first few months of life, when the stomach is, as it were, unfolding to its duties, can do nothing but misdirect the education of this organ.

In addition to being thus afflicted, the modern infant is becoming unnecessarily and increasingly subjected to the pernicious practice of feeding with artificial milk substitutes, either as a result of the blandishments of advertisements or through those calls of society which necessitate the abrogation, in whole or in part, of the chief of the maternal duties. It is not unknown for some mothers voluntarily to withhold the breast from their benighted children in order that they may the more conveniently indulge their selfish pleasures. As everyone knows, all sorts of concoctions are abroad which are supposed to outdo Nature in appropriateness of composition and directness of aim. Some of these are wholly unfit for infant foods and in their administration one is but sowing the wind to reap an inevitable whirlwind.

There is no doubt as to the superiority of the human breast, which has clearly been painstakingly designed to meet the very need of the suckling infant; for the more the skilful and delicate function of this organ is subjected to investigation and experimentation, the more it becomes apparent that Nature has overcome all those impediments and avoided all those pitfalls that have been the undoing of the modern artificial feeding contrivances. Nature's feeding-apparatus is one which, by collapsing as it is emptied, cunningly avoids the formation of a vacuum, with its consequent exhaustion of the infant and prolongation of the nursing-time. Moreover, recent researches have revealed in the breast a most admirable network of nervous pathways, which undoubtedly fulfil Nature's purpose by only allowing this organ to yield milk of a most excellent quality, at carefully regulated intervals. The wonder of this daily control is surpassed only by the breast's perfect anticipation of the day by day increase in the demand made by the healthy growing infant—not to mention the observations of the mammalian embryologist, that indicate that even before the infant has itself been weaned, the breasts of the little creature are already carefully preparing for their own lactiferous duties.

One need look no farther than the precincts of this great hospital, where our eminent mentors unerringly continue in their arduous tasks, for a living testimony of the long-lasting value of good, wholesome milk furnished by the breast, which, we are confident, they must have received.

The author is indebted to Professor Still and Dr. Keating, from whose script there has been liberal quotation
Disease of Children, 1913. Prof. G. F. Still.
T. W. Rotch, M.D.—Cyclopaedia of the Disease of Children, 180. Edited, J. Keating.

A Study in Progressive Physical Development

Convincing Testimony from the Mother

BABY "EUSTACE"
Aged 6½ months, fed from birth on the "Allenburys" Foods

Same boy aged 4 years.

Same boy aged 8 years.

Same boy aged 12 years.

THE MOTHER'S TESTIMONY

"I am enclosing you some more photographs of my eldest son, Eustace. He is now just over twelve years of age, and thanks to his splendid constitution which was built up on the 'Allenburys' Foods with which he was fed from birth, he is well and strong, and has escaped the illnesses so prevalent with children up to his age."

WORLD WIDE TESTIMONY

The "Allenburys" Foods provide a Pure and Complete Dietary, and contain all the essential elements for promoting brain and body development.

An ever increasing volume of testimony to their great value is received from Medical Men, Nurses and Parents resident in nearly all parts of the world.

The "Allenburys" MILK FOOD No. 1
From birth to 3 months.

The "Allenburys" MILK FOOD No. 2
From 3 to 6 months.

The "Allenburys" Foods

The Simplest and Best Method of Infant Feeding

The "Allenburys" MALTED FOOD No. 3
From 6 months upwards.

The "Allenburys" RUSKS (MALTED)
From 10 months upwards.

Pamphlet on Infant Feeding free from ALLEN & HANBURYS LTD., Lombard St., LONDON.

WHO'S WHO IN THE CAR PARK

For many years, much of the romance of the consultants' paraphernalia has been parked in the forecourts of the London teaching hospitals. In these tiny venerated car parks, some of the world's greatest chauffeurs wait in their limousines reading the gossip columns of a perfumed *Tatler* or a worn-out *Daily Mirror*. While their employers take wide-eyed students on guided tours of selected abdomens and chests, they arrange the untouched *Lancet* conspicuously on the back seat, sweep out the cigarette ash and figit nervously with the licence disc, which still says "tax applied for". These large black success symbols, their lush carpets, cigar lighters and cocktail cabinets all tell a story about the man. The chauffeur usually tells another.

Surgeons, resolute, ambitious and inexhaustible, own resolute, ambitious and inexhaustible cars which they can't handle and leave to their chauffeurs. A few have Minis. The physician chooses his car on the size of its instrument panel. The minimum requirements are instruments that record oil pressure and temperature four-hourly, while the "in-thing" is a gadget that x-rays and biopsies the air filter automatically. If there is any difficulty in distinguishing physicians from surgeons, their driving habits are conclusive; the physician is the one who goes three times round a round-about, disappears down the correct turning, only to reappear a few minutes later to have another look at the signpost. The surgeon, however, drives straight over the roundabout, down the wrong turning, reappears immediately and removes the signpost.

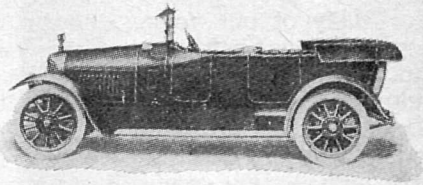
Obstetricians and gynaecologists are more like surgeons than surgeons. Their cars are out to catch the female eye and often mount the kerb in this pursuit. Unlike them, the cars of the E.N.T. surgeons have elaborate silencers and can be driven into a clinical lecture without waking a single student. Ophthalmologists' cars are designed with the myopic car spotter in mind and a few have vertical number plates with a diminishing type-face as an optional extra. Occasionally the paediatrician, who knows how horrible it all is, and how nice it is to climb back inside now and again, drives a van to oblige.

No mention has been made of anaesthetists' cars, which, of course, are all air and gas with chrome fittings, or the physiologists, who stand on their seats to see out of the windscreen and still have difficulty. But it is the psychiatrists who, opening, closing and checking their doors a suspicious number of times pass unnoticed, as they self-consciously hide their cars in their discreet car park just in case the front forecourt should be mistaken for the Earls Court Motor Show.

The Sign of the Quality Car

Crossley

"of Gas Engine Fame"



The Sign of

The Quality Car.

The Car of To-morrow.

THE car of to-morrow will have to attain a higher standard of service, economy, and appearance than the car of yesterday. During the war there has been, so to speak, a breach in the manufacture of motor cars for private use, but this breach is the forerunner of great and pleasant surprises.

After the war, motoring will assume a new rôle, a rôle of greater pleasure, greater safety, and greater economy. Better cars will be on the market.

The Crossley, for instance, though *always* accepted as "The Quality Car," will take on a new significance. Its record during the war will cause all who study values to consider the significance of such proved performance when contemplating the purchase of their cars for to-morrow. Is it not worth your while to wait for the new Crossley?

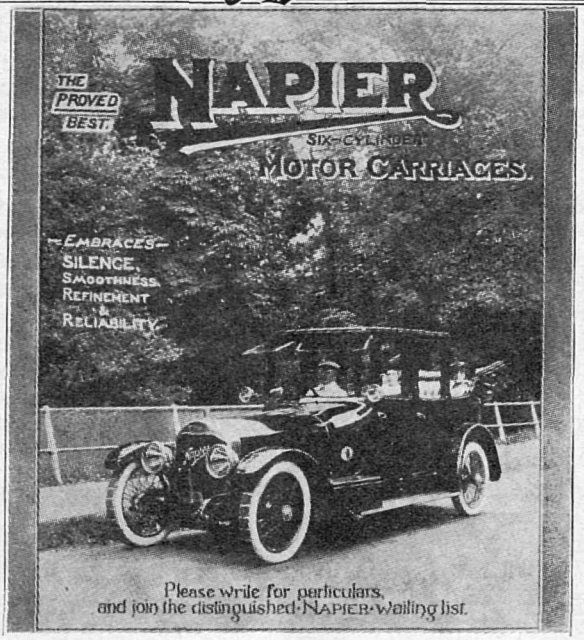
CROSSLEY MOTORS, LIMITED,

Builders of Quality Cars.

Telephone: City 4611 (3 lines). MANCHESTER. Telegrams: "Motors, Gorton."

London Office and Service Depot:
50, PAGE STREET, WESTMINSTER, S.W. 1.

Crossley



TO THE PUTTING ON OF CONSULTANT HAIRS

Many of our young students up from the country have discovered, long before ever they sit for their examinations in the Apothecaries' Hall, that there is much advantage to be gained by the cultivation of an eager, almost appealing, amiability towards the more senior members of the hospital staff. A spacious sense of the amplitude of life's possibilities encourages them to laugh at each and every joke with a truly competitive sincerity and to imitate with a most needful solicitude every detail of the consultant demeanour.

Unfortunately in these hirsute days of Beatle and circumbendibile Stone, most of our gentlemen of dignity and excellence have been modestly deterred from fully expressing their eminent personae with the customary outward display of keratinized splendour as did their great forebears such as Bright, Hodgkin and Wilks. Nevertheless, they are by no means all bald; indeed some, Professors included, have hair resplendent enough to grace a poet. The confidence which this inspires in their patients is famous enough to have been noised abroad, and it is well-known that many otherwise hopeless cases have been snatched from the jaws of death by this alone. The right coiffure is, indeed, not only curative, but prophylactic as well. One young girl records that she ambitiously obtained "just a few strands" from the head of one of our celebrated physicians and keeping them " as sort of talisman," she swears they preserved her from contracting Dengue Fever and many other maladies throughout a long week-end in Eastbourne.

However, the purpose of this work is not to inform you of what is already quite common knowledge, but it is written in recognition of the high esteem, that the average student places upon obtaining an appointment to the House. Notwithstanding the fact that some consultants will accept a banker's order, we felt that our more serious-minded Christmas readers would welcome the news that a long established firm of the Borough has started production on a new line of horsehair wigs. These have been made with the utmost diligence, and we can personally vouchsafe for their exactitude, in some instances right down to the matching of brilliantine.

This we know will cause much excitement, for ways of discreetly pleasing have been growing fewer year by year. Now for the outlay of a meagre few guineas, every student can discover the truth of the twin adages: " Imitation is the sincerest form of flattery," and " If one wears the hair of one's master, one soon steps into his shoes." In addition, he will be in premature possession of one of Nature's most powerful instruments for therapy. Write me now.

YOU SIMPLY COMB IT THRO'

None of the embarrassing details of an elaborate process. Any time, in your own room, simply by combing Seegerol through, you can restore to your hair an absolutely *natural*, *permanent* and *washable* shade.

Over 750,000 people have proved the integrity of Seegerol by actual use. Twenty-five years' reputation guarantees its trustworthiness. Seegerol is entirely free from the harmful ingredients of mineral or chemical extracts. Containing no acid, it cannot scorch the hair; absolutely non-greasy, it cannot produce a heavy stickiness. The highest medical certificate of the excellence, purity and actual harmlessness of Seegerol accompanies each bottle.

Seegerol costs 2/6 the flask, of all chemists, stores and hairdressers everywhere. It is supplied in the following shades: brown, dark brown, light brown, black, golden, auburn or blonde.

SEEGEROL LABORATORIES 1, Tabernacle Street, Finsbury, London, E.C. 2.

Wholesale Agents for Australasia:
Toilet Table Articles, Ltd., 56, Pitt Street, Sydney, New South Wales.

SEEGEROL FOR GREY HAIR

GUY'S and UNICEF

by Professor D. J. Anderson

Since 1963, many people at Guy's have given their support to UNICEF, and by the end of this year over £600 will have been distributed for the Nutrition Project in Uttar Pradesh State, India. Although this is a splendid sum, there has been a noticeable decline in contributions in recent months. The object of this report is to remind people about UNICEF and to acquaint them with new developments.

Faced with the welter of initials standing for so many organisations, fictitious and real, such as UNCLE and SISTER, many of us have given up trying to fit names to them. Even students have been known to use the initials ATP without knowing what they stand for. So a reminder that the initials UNICEF stand for the United Nations Children's Fund may be worthwhile.

UNICEF originally came into existence as an emergency fund for children, but lost its emergency nature long ago and now provides medical care and educational opportunities for mothers and children, as well as food when necessary. However, the emphasis now is on efforts to "help the children to help themselves", and much of the money spent in the Uttar Pradesh project was directed towards improving nutrition by education and by projects to elevate local food production both in quantity and quality.

In recognition of the contributions to peace of the UNICEF programmes throughout the world, the Norwegian Parliament recently awarded the Nobel Peace Prize for 1965 to UNICEF. This prize, amounting to about £18,000, was presented to a representative of UNICEF on 10th December.

A very important feature of UNICEF schemes is that they are jointly undertaken and financed by the local Government and by UNICEF. The contribution of the Government is usually between one-half and two-thirds of the cost. UNICEF does not provide assistance unless the Government has worked out all the details of the project and had them approved by a suitable U.N. agency or agencies.

It is natural for people who support activities by UNICEF and similar bodies to wish to know where and how their money is being spent. Although more direct sponsoring of projects in the manner of some other welfare organisations is impracticable, the U.K. Committee for UNICEF is meeting this desire by taking the sole responsibility for raising the funds needed for three UNICEF projects, which will offer to the supporters the choice of area they wish to help and greater details of how their money will be used, as well as the opportunity for the Committee to give them progress reports. Two of them are an expansion of Mother and Child health services in Nigeria and Malaysia, and the third is an expansion of the Singapore school dental service. In all three, the local Governments are providing between £2 10s. 0d. and £3 10s. 0d. for every £1 0s. 0d. coming from UNICEF. In Nigeria, where at present there is one doctor to 33,000 people, UNICEF assistance is being directed towards the expansion of the rural health services by the provision of equipment and by training community nurses and health tutorial staff. The estimated total of funds required to enable UNICEF to do this is £105,000. Approximately three times this amount will be provided by Central and Local Governments of Nigeria.

The aid for Malaysia will be directed to Sabah and Sarawak and, as in Nigeria, it will be concerned mainly with health services and health education. UNICEF supplies will include medical, dental and midwifery equipment, bicycles, land-rovers and other transport. Some of the districts are accessible only by water and so outboard motors are included in the list of equipment to be purchased. The cost to UNICEF will be £100,000, and the Malaysian Government will provide approximately £250,000.

In Singapore, the project is entirely confined to the school dental scheme and the objective is a dental clinic in every school. UNICEF will provide £6,800 during 1965-66, and the Government will spend about £24,000 over the same period.

These schemes ought to have a strong appeal here at Guy's and those of us who organise the collections hope for renewed support.

Recently a cheque for £39 0s. 0d. came to us from the proceeds of the Dental Ball and once again the Music Club has kindly offered us the proceeds of their concert to be given in Southwark Cathedral on Tuesday, 14th December.

THE GUY GAME

37. REGISTRATION. But don't stop here—make up own game and carry on.

36. Prescription for 2 pints Antifreeze queried. Correspond until end of game.

35.

4. Chief asks name tailor—move to next quare.

33.

32. Shaky sign-ups. Throw A6 for House job to stay in game.

26. Diagnosis wrong —return to 14 and repeat F.B.P. x 3 to learn humility.

27.

28. Marry nurse before qualifying — professional suicide. Retire.

9.

31. —OK, wise guy, crawl away and infest square 13.

25.

24. Not recognised on round—return to 17 and repeat firm.

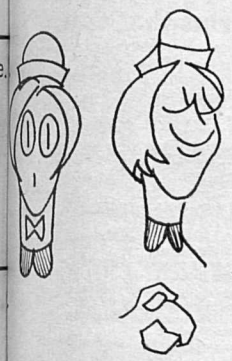
23.

21. Make flashy diagnosis—advance to 26.

14. More gossip in Nurses' Home — all nurses playing go back to start.

15.

16. Masonic square. Crowded, isn't it?



18. Paralytic again—return to 12 or reform. You are not taking this game seriously enough.

19.

12. Drunk at 1st Firm Dinner — miss throw to recover.

11.

10.

umours in Nurses' me—move quickly next square.

8. Take throw off to buy clinisuit and get haircut.

7. Arrive from Oxbridge — allowed two dice for all subsequent throws.

1. If father not at Guy's throw 6 to start.

2. Bad start. If female, throw again before being forcibly emancipated.

3.

Little better. Thank heavens you play rugby anyway.

You have swallowed a stomach tube miss several throws recover.

5.

6. Fail 2nd M.B.—return to 4 and keep trying.

YOUR CHRISTMAS DRUGS

How hospitals cure serious Liver, Kidney, and Bladder Disorders. —Alice Landies, qualified Guy's nurse, says: Drink ordinary saltrated water for permanent results.

EVANS' *Pastilles*

The effective precautionary measure against the microbes of Influenza, Catarrh, Pneumonia, Diphtheria, etc.

The unique antiseptic qualities possessed by Evans' Pastilles aid the natural resistance against all microbes which attack the mouth and throat. The Pastilles are made from a private formula, and they are free from poisonous alkaloids. They strengthen the vocal chords, allay and prevent irritation of the throat, and loosen any mucous secretions which may be present.

TRENCH ODOURS Evans' Pastilles are splendid for preventing the unpleasant effects which result from trench odours, and they are invaluable for service conditions. Send a tin to the Front.

Even in perfectly healthy throats there are myriads of these microbes—the Micrococcus Catarrhalis. They only await a chance to attack when the throat is weakened or inflamed. Evans' Pastilles will work against these microbes.

The Bacillus Influenzæ which is responsible for all cases of Influenza. These illustrations are from actual microphotographs of the microbes magnified 650 diameters, taken at our Runcorn Bacteriological Laboratories.

The undoubted success which has attended the use of Evans' Pastilles has produced a good number of worthless substitutes. To protect the public and to prevent substitution, we have reproduced here the Pastille and box for reference.

Obtainable from all Chemists and Stores, or post free from the makers— **1/3** *per tin.*

Evans Sons Lescher & Webb Ld.
56, Hanover Street - - Liverpool.
And at London and New York.

Each Pastille can be recognized by a raised bar marking, and none are genuine without this mark.

"See the raised bar on each Pastille."

℗ W/c

The **FRENCH** Natural Mineral Water

VICHY-CÉLESTINS

for disorders of the LIVER; GOUT, GRAVEL, DIABETES, RHEUMATISM and all ailments arising from Uric Acid.

N.B.—The Springs are situated in FRANCE, in the department of the Allier, and are the property of the

FRENCH GOVERNMENT

Can be obtained at all Chemists, Grocers, Wine Merchants, Stores and Hotels throughout the world.

Wholesale Agents—**INGRAM & ROYLE, Ltd.,**
Bangor Wharf, Belvedere Road, London, S.E.; and at Liverpool and Bristol.

Free your Mouth & Throat from the Germs that cause

"ALL for Health!" was the new National watchword recently proposed by Mr. John Galsworthy.

Do you endorse it?—then you should join the huge and increasing army of people who daily use Formamint Tablets to keep their mouths and throats free from harmful bacteria.

"*Oral asepsis*" the doctors call this condition, and they know how vitally important it is for defending the body against a multitude of dangerous germ-diseases.

They know, for example, that when a consumptive coughs or sneezes he literally sprays the air with tubercle bacilli which may easily infect anyone whose mouth is in an unhealthy state.

Protect yourself, now and always, by the regular use of Formamint. It will be worth your while—if only to escape the troublesome Colds and Sore Throats which you are otherwise almost certain to catch.

Influenza
Sore Throat
Tonsillitis
Quinsy
Laryngitis
Diphtheria
Measles
Mumps
Pyorrhœa
Abscesses
Gumboils
Dental Decay
Spongy Gums
Tainted Breath
Sore Mouth
Scarlet Fever
Consumption
—and numerous other conditions

Every day use genuine
FORMAMINT
The Germ-killing Throat Tablet

Formamint costs you no more than the so-called "antiseptic" mouth-washes, which are incapable of producing true oral asepsis. But do not imagine that Formamint is only a preventive—its curative and healing properties are no less remarkable—especially in local affections like sore throat and tonsillitis.

Buy a bottle at your chemist's to-day, price 2/2, but see that it bears our name and address on the label—otherwise you may get an inferior substitute.

The genuine original tablets are guaranteed to be absolutely harmless, and are so palatable that even children take them readily—a fact worth remembering during school epidemics when the youngsters must be protected.

"I have no hesitation in stating that in Formamint Tablets we have an absolutely safe and certain way of keeping the Mouth and Throat free from Germ Infection."
Dr. W. L. HOWARD, M.D.

GENATOSAN, LTD. (British Purchasers of the Sanatogen Co.), Chairman: LADY MACKWORTH, 12, CHENIES ST., LONDON, W.C. 1

Note: To protect you from substitution, Formamint will later on be given a new name, which will be announced shortly.

TO ALL WHO SUFFER FROM NERVES

INDIGESTION—CONSTIPATION—NERVOUS DEPRESSION—GENERAL DEBILITY—LOSS OF ENERGY.

FREE at an Interview or by Post ALL ABOUT MY METHOD of HEALTH and YOUTH RENEWAL.

IF it were to happen that you met Ten Thousand Men and Women who had suffered from just the same complaint or physical nervous weakness as you suffer from. If each of them one after another told you in enthusiastic terms how wonderfully they had been cured and set up again as strong, robust, full-blooded men and women in the full enjoyment of bold, hearty, healthy vigour, the clock of life set back ten years or more, by a single scientific, Electrological Appliance, at a cost within practically everyone's reach, would you wait a single day before considering whether you had better try the same remarkable remedy?

A NOTABLE OFFER.

The Superintendent of the Electrological Institute places at your disposal the reports of more than 10,000 previously enervated, weak men and women who suffered from

NERVOUS EXHAUSTION, INSOMNIA, RHEUMATISM, SCIATICA, INDIGESTION, OR PHYSICAL WEAKNESS.

Each of these formerly suffering people to-day cannot speak too highly of what the remarkable Pulvermacher Treatment has done for them.

In addition to that you have the further fact that the Treatment is endorsed by the four different Royal Physicians and the leading Doctors of Nine London Hospitals and many other medical men whose names rank high on the roll of medical fame.

One of these, Dr. C. Handfield Jones, F.R.C.P., F.R.S., Physician to St. Mary's Hospital, says—"I am satisfied that Mr. Pulvermacher is an honest and earnest labourer in the field of science, and I think he deserves to meet with every encouragement from the profession and from scientific men."

Besides this, the superintendent places his own experience and advice at your disposal without involving any obligation upon you to take up the treatment.

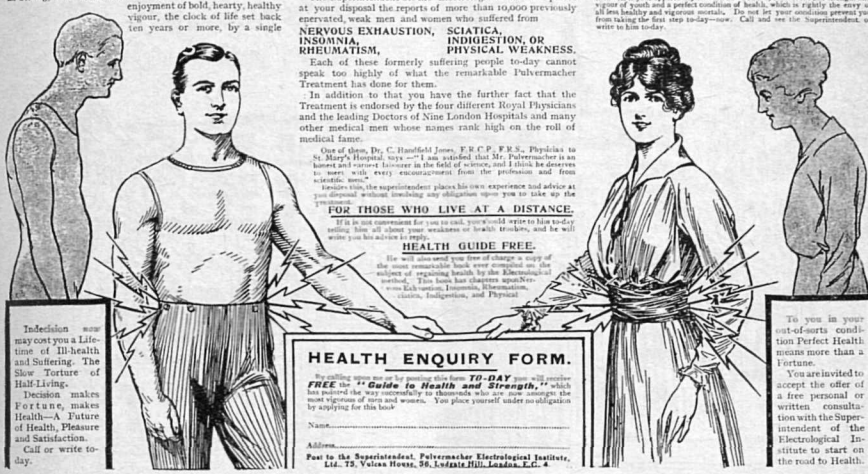
FOR THOSE WHO LIVE AT A DISTANCE.

If it is not convenient for you to call, you should write to him to-day telling him all about your weakness or health troubles, and he will write you his advice in reply.

HEALTH GUIDE FREE.

He will also send you free of charge a copy of the most remarkable book ever compiled on the subject of regaining health by the Electrological method. This book has chapters upon Nervousness Exhaustion, Insomnia, Rheumatism, Sciatica, Indigestion, and Physical Weakness. It also contains the signed opinions of the great Physicians whose names are household words, and a quantity of general health information every man and woman should know.

If you are one of those who are walking on the edge of the abyss of broken health and impaired vitality, the symptoms of which are a gradual lessening of healthy vigour, a general lassitude, the inability to concentrate the mind, to enjoy work or pleasure, a nervous indecision in matters of importance, impaired digestion, or any of the ailments which arise from a disordered nervous system, then this is your opportunity to learn how you may recover the lost strength and vigour of youth and a perfect condition of health, which is rightly the envy of all less healthy and vigorous mortals. Do not let your confusion prevent you from taking the first step to-day—now. Call and see the Superintendent, or write to him to-day.



Indecision now may cost you a Lifetime of Ill-health and Suffering. The Slow Torture of Half-Living.

Decision makes Fortune, makes Health—A Future of Health, Pleasure and Satisfaction.

Call or write to-day.

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By calling upon me or by posting this form ***TO-DAY*** you will receive ***FREE*** the ***"Guide to Health and Strength,"*** which has paved the way successfully to thousands who are now amongst the most vigorous of men and women. You place yourself under no obligation by applying for this book.

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To you in your out-of-sorts condition Perfect Health means more than a Fortune.

You are invited to accept the offer of a free personal or written consultation with the Superintendent of the Electrological Institute to start on the road to Health.

That's what you want for your Skin Trouble

A Laxative and Refreshing Fruit Lozenge FOR

CONSTIPATION

Gastric and Intestinal Troubles

TAMAR INDIEN GRILLON

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Sold by all Chemists, **3/-** a box.

HIMROD'S ASTHMA CURE

If you suffer from Asthma, Catarrh, Ordinary Colds, you will find nothing to equal **HIMROD'S CURE FOR ASTHMA**

At all chemists 4/3 a tin.

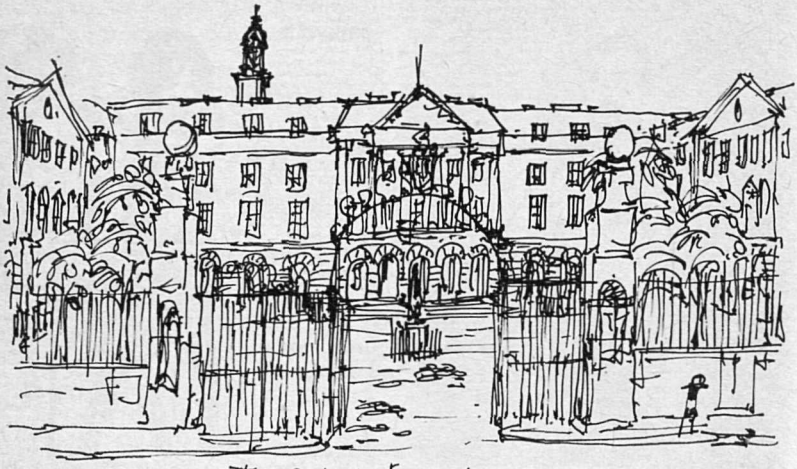
BROWN'S BRONCHIAL TROCHES

Relief for All.

IN THE SUMMER-TIME, when your **THROAT** is dry and irritable, or if troubled with **ASTHMA** or a **FIDGETY COUGH** you will obtain great relief if you give these **TROCHES** a trial. The Lozenge for Singers and Speakers.

GUY'S HOSPITAL 1965

Recent drawings by Neil Watson



The Restored Forecourt

The Colonnade

A Page of Pernicious Rumours

It is rumoured that Lord Snowdon is designing a guinea pig cage for the animal house.

It is rumoured that the tower block is to be devoted entirely to the shoe fitting department.

It is rumoured that the College will be pulled down.

It is rumoured that the New Spit will live up to expectorations.

It is rumoured that Dr. Scott sent Professor Warwick a box of Black Magic.

It is rumoured that New Guy's House is to be restored.

It is rumoured that Picasso has been appointed to the Medical Illustration Department.

It is rumoured that Dr. Baker forgot to censor this edition.

It is rumoured that the Bloomfield Clinic has woodworm.

It is rumoured that the queues to the Spit are causing congestion on London Bridge.

It is rumoured that Mr. Wheeler's dog has been treated for dermatitis artefacta by Dr. Forman.

It is rumoured that Billy Butlin has made a take-over bid for the York Clinic.

It is rumoured that Mr. Clarkson is making certain alterations to the noses in the Towne Collection.

It is rumoured that Coronation Street is being televised direct from the Bloomfield Clinic.

Guy's All-Time Records

The largest number of "yes sirs" per round—420 by a junior dresser bent on a house job (3 were acknowledged).

Dr. Moynahan's longest out-patients—8 days.

Closest student to Professor Robson in a Pharmacology lecture—2nd row from the back.

The cheapest 4-course meal at the spit—1 sausage roll, 2 chips and a garden pea: 13s. 6d. (fresh undiluted water—free).

The fastest reaction to an emergency call—the works department—3 days, 5 broken promises, 7 apologies.

The longest time a lift has been working in Hunt's house—3 hours, 5 mins., $2\frac{1}{2}$ floors.

The longest bleep—2 roods.

Voted the most down to earth being in the hospital—Mr. Wheeler's dog.

The most significant thing dug up at the recent archaeological excavation behind New Guy's House—8 tons of dirt.

The fastest time for the production of a stethoscope at a consultant's request—one P—R interval.

The largest number of working microscopes in the student laboratory—$1\frac{1}{2}$.

Obiter Dicta

DR. STAFFORD-CLARK—"The Queen is usually polite to me."

PROFESSOR HUNT—"The normal is that which has not been fully investigated."

DR. MAC KEITH—"Love is nothing but contact between two skins."

A PATIENT—"Next week my son is sitting for his E.C.G."

MR. GIBBERD—"You can bend babies—they're made of plastic."

MR. ECKOFF—"We chaps of my age don't read books—we write 'em."

MR. GAZET—"I don't know anything about diabetes, but I'll talk about it."

RESIDENT ANAESTHETIST—"I am going to try and put her to sleep without waking her up."

DR. KAUNTZE—"I haven't had much success with gold . . . . . therapeutically speaking."

DR. MANN examining a male patient—"You see, it doesn't feel like an ovarian cyst."

A PATIENT—"The doctor gave me a digitalis examination."

MR. READING—"Ear drops are eye wash."

MATRON to a group of nurses—"So now you are all going to be centrally sterilized."

DR. KAUNTZE, surveying an empty clinic—"This country is being swept by an epidemic of health."

MR. STAMM—"A human being is a two-legged individual with a pain in his back."

VISITOR standing in front of the collonade—"Could you tell me where the main entrance is?"

THREE GODDESSES AND A GUY'S MAN

by H. St.H. VERTUE

A man was born, sang, suffered, loved and died:
Come, let us praise him: here is nought to hide.

Swinburne.

Mount the steps of the Medical School press the door handle and enter: on your left is a tablet commemorating Keats. I derive from it a little glow of satisfaction because of the fellowship that I feel with that admirable man, for Keats was a Guy's man, a good man, a sensible man, an excellent son, a devoted brother, a man above whom shines "the double aureole of poetry and friendship" (Colvin). He did not pose; he did not put on side; he was not unbalanced by the possession of genius. In a whole man Mars and Venus both have abode; in a wise man they are so united that a daughter Harmonia is born. Keats was small, but muscular and plucky; as a schoolboy he was a fighter; as a grown man he thrashed a butcher for ill-treating his horse. At Wipers or on the beaches of Dunkirk he would have given a proper account of himself; but the times did not call him to grasp the sword or embark on the vessel of war. Therefore we are to follow a path of quite a different kind, one that wound away before an eager, youthful poet, guided by the goddesses who loved him, whom he loved.

Man's voice is on the mountains; and the mass
Of nature's lives and wonders pulse tenfold,
To feel that sunrise and its glories old.

I had not re-read the *Endymion* for fifteen years and therefore, when I did so, brought to it a fresh mind and found in it new treasures. To complete the poem Keats betook himself to a beautiful part of Surrey near Boxhill; and because I knew that land before the builders had invaded it or the motor-car had been invented, Keats's Greece is my Greece: —

Clear summer has forth walked
Unto the clover-sward and she has talked
Full soothingly to every nested finch—

and I have never allowed that joint illusion to be destroyed. The myth that he used is simple enough. Selene, the moon, is enamoured of Endymion, the beautiful shepherd, who is laid asleep on Mount Latmos; and nightly she visits him and bestows a kiss. Selene eventually became merged in Artemis, the Virgin Huntress of Arcadia, sister of Apollo the sun-god; but Keats always calls that goddess

"Diana", a Latin equivalent. To me Artemis is Artemis, she to whom the huntsman cried "Kallista! Kallista! Fairest! Fairest!"

Before the goddess came, there had been a prelude to love in Endymion's life, warm breath, soft hands and taper fingers of one who was for him halfway between the mother and the bride, Peona. It is a very pretty piece of work and a few lines are worth quoting, because they give so well the sense and style of the *Endymion*.

> Who whispers him so pantingly and close?
> Peona, his sweet sister: of all those
> His friends, the dearest. Hushing signs she made
> And breathed a sister's sorrow to persuade
> A yielding up, a cradling on her care.
> Her eloquence did breathe away the curse:
> She led him like some midnight spirit, nurse
> Of happy changes in emphatic dreams,
> Along a path between two little streams,
> Guarding his forehead with her round elbow
> From low-grown branches, and his footsteps slow
> From stumbling over stumps and hillocks small,
> Until they came to where those streamlets fall
> Into a river.

Endymion is still like a child, guided, loved and protected by a woman; but he is well aware of her beauty. The sister-nurse then leads him to a quiet bower and holding his hand, soothes him to sleep; and when he wakes he tells her everything.

The innocent begins his story to his sister with a word that women favour, of significance I think,

> The *loveliest* moon that ever silvered o'er
> A shell for Neptune's goblet.

Enemies of the romantic movement would like us to believe that the romantics were immoral fellows, posers, self-pitiers and imperfect ablutioners; but the English Muse of romantic verse, opening her lips to breathe "The curfew tolls the knell of parting day," closing them with her last suspiration "I hope to see my Pilot face to face, when I have crossed the bar," was purest-lipped, country-bred and healthy.

Our simple shepherd goes on to describe the goddess's epiphany.

> Again I look'd, and, O ye deities,
> Who from Olympus watch our destinies!
> Whence that completed form of all completeness?
> Whence came that high perfection of all sweetness?
> Speak, stubborn earth, and tell me where, O where
> Hast thou a symbol of her golden hair?
> Not oat-sheaves drooping to the western sun—

and here follows a typical blunder of the early Keats, which I omit—

> —and yet she had
> Indeed looks bright enough to make me mad;
> And they were simply gordian'd up and braided,
> Leaving in naked comeliness, unshaded,
> Her pearl round ears, white neck and orbed brow.

"Simply" here means "absolutely". "Gordian'd up" is an experiment in enlarging poetic diction. Cynthia, having had her tresses braided, knots them on the crown of her head to display the full beauty of her neck and ears. The effect will be something like that of Bronzino's Venus (National Gallery). "Pearl round ears" exhibits compression of thought. There is first the image of a pretty ear with a pearl inserted in the lobe, for she has tactfully assumed a sea-nymph's guise: "Art a maid of the waters?" he exclaims, "One of shell-winding Triton's bright-haired daughters?" Secondly, there is the simile of the shell for a beautiful ear: compare Psyche's " soft conched ear". "Orbed brow" denotes the noble forehead and broad brow of a woman of high intelligence, which curves away handsomely at the temples. Finally, she softens her clear, pure beauty and emphasizes her modesty with a scarf, blue spangled with white, daisies on a bluebell bed.

What an extraordinary work of art is this picture of a beautiful woman, done in words and in words alone! The painted picture is for ever still; but Keats's Artemis lives, moves and breathes.

How happy was the lot of the young Keats, who lived in a fair land, where none intruded; who was a poet and knew it; who had the affections, which are "in themselves the highest pleasures and enjoyments" as Shaftesbury says, adding that "to have entire affection is to live according to Nature and the dictates and rules of supreme wisdom"; for whom the ideas of beauty and good were embodied in woman, in "beauty clear and fair, where the air rather like a perfume dwells," beauty supreme in a goddess whose boon was the blend of love and awe essential for true poetry! If any thoughts about women that were less pleasant did obtrude themselves, Keats put them down to some fault that he imputed to himself. To those who have any knowledge of psychology it will be plain that he had an exceptional mother. In fact, she was tall and handsome, lively and intelligent, fond of amusement but sensible withal. An excellent and affectionate parent, she was devoted to her son John, who returned her ardour. "Had she withheld the succour she supplied," sings the son of Iolanthe, "by hunger quelled your Strephon might have died!" Just so! And had Mrs. Keats not supplied the right nutriment for her son's genius, that genius would never have developed.

The second epiphany of Artemis is not so splendid a work of art as the first. The goddess does indeed appear as a goddess and not "as a very maid, blushing, waning, willing and afraid." She discards also her scarf and assumes a fine boldness ; but her dismay at "Minerva's start" and "Jove's sad look", is comical. As for Endymion, he has become quite passive. He only wants to be for ever in her arms, to kiss her "toying hands" and feel for ever her breath about his brow. Our Endymion is reverting to childhood: he is (sweet word!) "infantilized". The truth is that the lovers are drawing back from that part of love that is concerned with propagation, because it

seems a thing too crude and primitive to be joined to their Platonism; and of the two Endymion recoils the more because he is abashed by the superiority of his bride. But Keats was a man of genius, a vigorous man, an inspired man: and before the work is over he has found a way out. It is no ordinary way: it is a very extraordinary way, but it is psychologically correct.

In the last book Endymion encounters an Indian girl, who is plainly inferior to Artemis. Set aside the moon-goddess's white neck and those "blush-tinted cheeks" of hers, the Indian girl's complexion would be a thing of nought; and how could *she*, with glossy curls of jet, ever be mistaken for "one of shell-winding Triton's bright-haired daughters"? She is arden and amorous, and she is pining for love. Furthermore, she had been a Bacchante, well acquainted with old Silenus and his crew; and she had nothing about her to suggest a particular purity. Therefore to Endymion she would not seem to be a thing above himself. In the language of the Freudiani she was not one to be "idealized" nor "desexualized" nor to become a "mother-substitute". In plain English, she was just what Endymion required. At once he fell in love with her, gave up his goddess and proved himself ripe for education. And then to our immense surprise and not a little to our amusement, we learn that the Indian girl is Artemis herself, that chaste goddess in disguise. The minx! She had had a consultation with Asklepios no doubt, who was much like Osler, with a spirit more attuned to the laughter of Democritus than to the tears of Heraclitus.

It is plain that a path was now open to the pair. "When a merry maiden marries, sorrow goes and pleasure tarries"; but there would have been objections to that plan. Mortals grow old and die, goddesses do not. Wedded to his goddess, Endymion would have had to die and come to life again, every year probably, a second Tammuz, another Attis. Keats himself was not fully aware of all that his genius had been concocting and persevered with the myth of Selene. Allow me therefore to present a parallel case, where the appropriate treatment was successful.

Once upon a time, in the beautiful island of Lesbos, lived Daphnis and Chloe, neighbours, the one a goatherd, the other a shepherdess, young and beautiful, loving each other like brother and sister. But one day Daphnis falls into a miry pit and is helped out by Chloe, who lets down her waist-band. Then she takes him to the spring of the Nymphs, washes all the mud off him and is suddenly filled with delight by what she is feeling and touching. They fall in love, but they are rather afraid of one another, Daphnis being especially afraid of hurting Chloe. There were, it is true, the sheep and the goats, but they did not seem to them to be good models of human behaviour. Then there came to them the young wife of an elderly husband, who felt sorry for the pair and was not above doing herself a good turn as well. She made up a little story about a lost goose, decoyed Daphnis into a wood and there bestowed on him some education, to such good effect that with the applause of the neighbours and the

blessing of the squire, he presently married Chloe. In due time a little family arrived and they all lived happily ever afterwards. The name of their benefactress was Lukainion, and to those who know their Latin and Greek it has a subtle significance.

A true Lukainion, not a counterfeit, presently entered the life of Keats and her name was the Beautiful Isabella Jones. Generous she was, witty and cheerful, and she did Keats great service by introducing him to the being of whom he stood most in need, the Aphrodite who leaves her father's house with a smile on her immortal countenance. Very soon children came forth, but they were not of flesh and blood: they were some of the most beautiful poems that the world has known.

How fortunate was Keats! Three goddesses inspired him with "warm breath, light whisper, tender semi-tone", the Mother-goddess, chaste Artemis and she whom men call "Gladness" or "Darling of gods and men". His life was short, but through those three he won all for which he craved.

> These are the living pleasures of the bard;
> But richer far posterity's award.

In a little more than a year after his great work was done he had died of phthisis, of the true hectic fever. Still the gods had shown their favour, for "many a time" he had "been half in love with easeful Death", ready to sink "before his goddess in a blissful swoon" (regression). Perhaps, after all Zeus gave ear to the moon-goddess and laid him asleep on Latmos; and there nightly, "queen and huntress, chaste and fair", she bends over her beloved poet and bestows on him her kiss.

Appendix.

Some matters of medical interest appear in Keats's final period of production. Features that invite attention are the frequency and rapidity of changes in mood and the intensity of the feeling evoked, now exaltation, now preponderating gloom, spells of feverish activity followed by immersion in *The Anatomy of Melancholy,* a creative activity that flared like a lamp and then went out completely, and a marked increase in sexual excitement (with Fanny Browne as the object). The phenomena are unconnected with the growing seriousness of a poet who had "set out for a nobler life" where he might "find the agonies, the strife of human hearts", achieve a Shakespearian range in fact (*Sleep and Poetry*); nor are they a natural response to a straitened means or malignant reviewers: they are things that would have been recognised by physicians of my youth as symptoms of early tuberculosis, "the stimulating effect of a tuberculous toxaemia." They would have been set down then as productions of organic disease, to be assigned to the same category as the rash of measles or the strawberry tongue of scarlet fever. Were they alive today, those physicians would indeed include among examples of corporeal illness many patients now bearing psychological labels; and experience has told me that not seldom they would be right. It is well to be aware of this. *A wise man does not deprecate life* (Epicurus).

CORRESPONDENCE

Neurotics

SIR,—I would like to comment on G. L. Davies' article on "Neurotics" in your issue of the 13th November, 1965. I started reading this quotation-studded article with sympathy and found myself in agreement with the author's assessment of the situation forty years ago when "Neurosis" was regarded with "scarcely veiled contempt."

I followed his subsequent arguments with some difficulty, but was astonished by his final few remarks which I quote:—

> "Cases such as these only go to show on what a tenuous foundation the diagnosis of neurosis frequently rests. It does not need much imagination to think of the possible tragedies which can follow upon a mistaken diagnosis of neurosis; a loss of interest perhaps on the part of her attendants, delay, a transfer perhaps to some quiet ward occupied by the really intractable, during which time organic signs and symptoms may develop apace. How much better, perhaps, instead of using the word 'neurosis' to be honest and say 'cause unknown,' and keep them in mind for further reviews if necessary, sine die, as the lawyers say."

Whatever contradictions and inconsistencies Dr. Davies' article contains, I would like to confine my comments to these last three sentences. Dr. Davies referred to the "tenuous foundation" of neurosis—he leaves us to infer what is meant by neurosis apart from the examples which he gives, and interestingly enough refers to "true neurosis" at one point implying that there is more than one kind. Neurosis, considered by many doctors to be an obsolescent word, consists of illnesses involving symptoms which we can understand in terms of our own feelings and experience, and which bring a patient to a doctor asking for help. These patients often present with somatic symptoms and may well emphasise physical complaints because they feel (perhaps not consciously) that the doctor will be more interested in these. No amount of laboratory or technical investigation will reveal "the cause" of the illness, which will remain untreated unless recognised. The diagnosis is made on positive grounds, usually following a carefully taken history and examination, but some further investigation may be necessary if a differential diagnosis is being considered.

Finally, sir, I accept the implication of the final two sentences. Mistakes in diagnosis do occur (although Dr. Davies' way of expressing it is perhaps as outmoded as the "scarcely veiled contempt" in the first part of his article), and we must all remain critical of ourselves and our work. The tragedy of the cases he refers to is equalled by the depressed patient whose physical symptoms are investigated at a number of hospitals before he brings attention to the true nature of his troubles by a determined effort to end his life. All of us, in the final analysis, are physicians who are interested in making the *correct diagnosis* so that we may treat our patients accordingly.

Yours, etc.,

D. I. BROUGH.

Department of Psychological Medicine,
Guy's Hospital.

Lord Brock

SIR,—2.30 p.m. on the afternoon of Wednesday, 1st December, was a very proud moment for Guy's Hospital. Lord Brock took his seat in the House of Lords, supported by his sponsors, Lord Brain and Lord Cohen.

The traditional and colourful ceremony was an occasion of pageantry which those of us who were privileged to watch will never ever forget. The importance of the event was signified by the large gathering of eminent medical men who had come to pay their respect to this outstanding member of our Staff.

As a typical gesture of the generosity he always shows to those who assist him, in however small a way, he invited three of us, members of the Nursing Staff, to lunch at the Royal College of Surgeons, and afterwards to watch him make his first appearance in the House of Lords.

We should like to take the opportunity of bringing this memorable occasion to the notice of your readers.

Yours, etc.,

MARGARET LAWS.

Theatres,
Guy's Hospital,
London, S.E.1.

NOTICES

Guy's Hospital Dental School

TRAVELLING SCHOLARSHIPS.

Attention is drawn to the undermentioned Travelling Scholarships which are now available.

Newland-Pedley Travelling Scholarship.

This Scholarship will be awarded to the holder of a registrable dental qualification, who has been educated at Guy's Hospital Dental School, to enable him or her to undertake a year's postgraduate dental study at an institution abroad approved by the Dental Council. The value of the Scholarship will be up to £1,000, and the actual amount of the award will depend upon whether the holder of the Scholarship proposes to spend a year at an institute in Europe or Scandinavia or whether the year will be spent in Canada or the United States. The holder of the Scholarship may be required to undertake teaching duties in this School for the academic year following that in which the Scholarship is held.

Dental Travelling Scholarship.

This Scholarship has a value of £250 and is awarded every third year to the holder of a registrable dental qualification, who has been educated at Guy's Hospital Dental School, to enable him or her to study at one or more Colonial or Foreign Dental Schools approved by the Dental Council.

Both these Scholarships will be offered for award in 1966. In order that applications for the Travelling Scholarships may be considered by the Dental Council in sufficient time to enable the successful candidates to make arrangements for travel, etc., it is necessary for all applications for Travelling Scholarships for 1966 to be received by the Dean of Dental Studies by 1st FEBRUARY, 1966.

The Dean of Dental Studies will be pleased to discuss the matter with anybody who is interested.

F. S. WARNER,
Dean of Dental Studies.

Hockey—Past v. Present

This season the hockey club has been in the envious position of being able to turn out six sides, which prospers both the standard and morale of the club.

This state of affairs has, of course, only been reached as a result of much hard work by many members over the years. It is felt that an opportunity for old and present members to meet once again should be created, and to facilitate this it has been proposed to arrange a fixture for the Past v. Present on Sunday, March 6th, 1966, at Honor Oak Park. Should there be sufficient response, two matches will be arranged for the same day.

Anyone who is interested in playing is invited to write to one of the undersigned as soon as possible. Further details will be sent out nearer the time.

Professor W. J. H. BUTTERFIELD (Hon. President),
R. LALLEMAND (Capt., 1960),
R. S. CARRUTHERS (Hon. Fixt. Sec.).

REVIEW

THE GUY'S INTERNAL TELEPHONE DIRECTORY.
August 1965 Edition.

It is not often one has the opportunity of reviewing a publication such as this, and I am indebted to the publishers for making it available to me. It is without doubt the most widely used—one cannot in all honesty say read—publications in the precincts of the hospital. Its growing popularity is as significant perhaps of the increasing amount of information it has to carry as of the increasing number of persons who find themselves so sorely in need of that information.

For example, where else could one find the information on how to telephone one's bank manager or loved-one. Or how could the would-be Don Juan obtain the number of the side entrance, no less, to the impregnable Matron's House?

In the department of Medical Social Work—"Almoner's" for erstwhile users of the publication under review—one can ring five out of the eight "rooms". Why only five? What dark episodes (and the department concerned conjures up quite a few) are lived out in rooms 5, 6 and 7 that they may not be interrupted by the ringing of a telephone bell?

Is it with any deeper psychological insight that the York Clinic has a "finance office" while the rest of the hospital has a "counting house"?

One of the startling revelations made by the Directory is that of the presence of a person who is apparently more highly qualified than most, yet most under-rated. Who would have known that if your problem is admissions outside office hours (sic), house officers, R.M.O's., R.S.O's., take-in A.H.S's. and dressers, Nuffield House patients or visiting chaplains, a quick single full turn of the dial will guarantee you assistance in any of these—you are told you only need to ask.

When the dreary London weather is engendering an abyssmal depression and sense of impending doom, please do not throw in the sponge. Your hospital has provided a consoling service at the other end of a telephone wire in much the same way as The Samaritans will talk you out of suicide. But your hospital offers you more than words. You need only ring extension 401 and you will obtain, yes dear reader, *sunlight.*

Christmas Cards

are **NOW** available.

The usual selection of Guy's Christmas Cards together with a few new designs are on sale at the Gazette Office.

We would like to take this opportunity also of reminding readers that etchings of Hospital views and other useful small gifts for Christmas are also on sale as usual.

Call at Gazette Office 16 St. Thomas St. and look through our range of WELCOME GIFTS

All this and much more is to be found in the latest edition. It all comes in a good, trusty, durable, suitably blue-coloured hard cover—paper-back versions as yet unavailable—and there is a special bonus in the form of a looped piece of fine blue cord for you to hang your copy on that annoying vacant hook and previously purposeless protruding nail. Another outstanding feature is the file-form of the binding to enable you to put your own personal annotations into this mine of information by merely punching a hole in them. But I don't feel like commenting on the standard of printing and layout.

I recommend this publication wholeheartedly as the ideal Guy's Christmas present of this year. It is the perfect gift for that young niece, nephew, daughter, son or friend, who is embarking upon a career at the hospital. For the more distinctive gift the establishment before hand of a new department or clinic will ensure the donation of his own entry into this numerical "Who's Who" of Guy's.

And remember, all the best people read it.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S-MAUDSLEY NEUROSURGICAL UNIT

Applications are invited for two posts of **Senior House Officer** (resident), one for the six months commencing 1st February, 1966, and the other for the six months commencing 1st March, 1966. The Unit, which is housed in the Maudsley Hospital serves both Guy's Hospital and the Bethlem Royal Hospital and the Maudsley Hospital. Applications should be made by **1st January, 1966,** to L. H. W. Paine, House Governor and Secretary, the Maudsley Hospital, Denmark Hill, S.E.5.

PERSONAL

If there is a Dental Surgeon wanting a position as assistant, an all-Guy's practice in the West End (principal and two assistants) looking for a successor for one of the leaving assistants, would welcome a call. WELbeck 9433 or Box No. 50. 5-day week, 9.30-6.00.

BIRTHS

CUNLIFFE-STEEL.—On April 11th, 1965, at Umtali, Rhodesia, to Tessa (née Metyard) S.R.N., and Philip Cunliffe-Steel, a son, Brooke Sean Mark.

GREENWOOD.—On December 8th, 1965, at 28, Woodfield Road, Coventry, to Annette (née Hasquencort) and Roger Greenwood, a daughter, Rosemary Jane, a sister for William.

MITCHINER.—On November 12th, 1965, at Mount Alvernia, Guildford, to Rosaleen (née Hawkins) S.R.N., and Dr. Michael Mitchiner, a daughter, Kathleen Mary.

CUNNINGHAM.—On October 9th, 1965, to Anne (née Pugh) S.R.N., S.C.M., and Gerald Cunningham, A.R.I.C.S., a son, Philip Neil.

WESSON.—On November 10th, at Nuffield House, Guy's Hospital, to Brynhild (née Watson) S.R.N., and Robert Wesson, a daughter (Susanna Catherine), a sister to Roger.

DEATHS

MILLIS.—On December 6th, 1965, peacefully, at 22a, Belvedere Grove, Wimbledon, S.W.19, late of Putney, Grosvenor Charles Millis, M.C., M.A., M.R.C.P.

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